76-1412

IN THE

Supreme Court of the United States

OCTOBER TERM 1977

No.

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell, Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Respondents.

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Richard McDonough, Commissioner of Insurance of the State of New Jersey, and James R. Cowan, M.D., Commissioner of Health of the State of New Jersey,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF NEW JERSEY

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On Petition

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Richard McDonough, Commissioner of Insurance of the State of New Jersey, and James R. Cowan, M.D., Commissioner of Health of the State of New Jersey,

---

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

Petitioners, John Borland, etc. et al., pray that a writ of certiorari issue to review the final judgments of the Supreme Court of the State of New Jersey, rendered in the above-captioned matter on January 13, 1977.

CITATIONS TO OPINIONS BELOW

The opinion of the Supreme Court of the State of New Jersey is published, *John Borland, etc., et al. v. Bayonne Hospital* and *John Borland, etc., et al., v. Richard McDonough, Commissioner of Insurance of the State of New Jersey, etc., et al.*, at 72 N.J. 15 (1977). The opinion of the Superior Court Appellate Division in *John Borland, etc., et al. v. Richard McDonough, Commissioner of Insurance of the State of New Jersey, etc., et al.*, is published at 135 N.J. Super. 200 (1975). (See Appendix 82a.) The opinion of the Superior Court Appellate Division in *John Borland, etc., et al. v. Bayonne Hospital, etc., et al.* is published at 136 N.J. Super. 60 (1975). (See Appendix 32a.) The opinion of the Superior Court Chancery Division in *John Borland, etc., et al. v. Bayonne Hospital, etc., et al.* is published at 122 N.J. Super. 387 (1973). (See Appendix 81a.)

JURISDICTION

The final judgment of the Superior Court, Chancery Division in the matter of *John Borland, etc., et al. v. Bayonne Hospital, etc., et al.* was entered on March 9, 1973, on motion for summary judgment in favor of Respondent hospitals and Respondent Hospital Service Plan of New Jersey. On April 13, 1973, Petitioner filed a notice of appeal to the Superior Court of New Jersey, Appellate Division. On October 19, 1973, an order was entered by the Superior Court, Chancery Division transferring the cause of action against Respondents Richard C. McDonough, Commissioner of Insurance and James R. Cowan, Commissioner of Health of the State of New Jersey (in accordance with N.J.C.R. 2:2-3(a)) to the Superior Court Appellate Division.[1] On January 24, 1974, the Superior Court, Appellate Division, remanded the matter of *John Borland, Jr., etc., et al. v. Richard McDonough, etc., et al.* to the Commissioner of Insurance for the purpose of expanding the record, particularly with respect to the method used and the factors considered in establishing the *per diem* rates of reimbursement payable by Respondent Hospital Service Plan of New Jersey to respondent hospitals herein. On July 3, 1975, the Superior Court of New Jersey, Appellate Division, affirmed the final summary judgment of the Superior Court of New Jersey, Chancery Division, 136 N.J. Super 60 (App. Div. 1975). On July 3 ,1975, the Appellate Division rendered final judgment against Petitioners in the companion case of *John Borland, etc., et al. v. Richard McDonough, etc., et al.* Thereafter, notices of appeal to the Supreme Court of the State of New Jersey were timely filed in both cases. On January 13, 1977, the Supreme Court of the State of New Jersey affirmed the final judgments of the courts below in a single opinion. The jurisdiction of this Court is invoked under 28 U.S.C.A. 1257(3), and the Fourteenth Amendment to the Constitution of the United States.

QUESTIONS PRESENTED

I

Whether the constitutional guarantee to equal protection under law is violated where, by statutory design

1. Though bifurcated by reason of the separate avenues to the Appellate Division, the matters were treated as companionate actions in both the Appellate Division and Supreme Court, being argued and determined together; thereafter, the Supreme Court issued one consolidated opinion.

or implementation, indigent care costs incurred by community medical facilities are "passed on" only to cash paying patient members of the community and are not shared by Hospital Service Corporation members of the community.

II

Whether a statutory scheme predicated upon a state legislative goal and objective ". . . to help the *community carry* the social and economic burden created when people are unable to pay for the necessary care rendered in hospitals" is violative of the constitutional guarantee to equal protection under law, where said scheme creates a separate classification of Hospital Service Corporation subscribers (presently comprising approximately 70% of the state's population) and those charged with the administration of said scheme arbitrarily and unreasonably exempt that section of the community from sharing said economic burden.

III

Whether the constitutional guarantee to Due Process of Law is transgressed where, by statutory scheme or implementation, a classification of Hospital Service Corporation subscribers is created, and thereafter, arbitrarily and unreasonably exempted from having to pay its pro rata share of the economic burden of indigent medical care (as well as other costs incurred by hospitals) which must be shared by all other patient members of the community.

IV

Whether the constitutional guarantee to Due Process of Law is violated where, by statutory design and/or implementation, a legislatively created class of Hospital Service Corporation subscribers is needlessly, arbitrarily and discriminately granted a non-functional below-cost basis discount on medical services and facilities, unrelated to a proper governmental purpose, resulting in the de facto subsidization of that class by all cash paying patients.

V

Whether the constitutional guarantee of Due Process of Law is transgressed where claimants asserting the violation of fundamental rights by unreasonable administrative action are, through Summary Judgment, denied the tools of discovery necessary to prove their cause, and thereafter, that Summary Judgment is affirmed upon the basis of a failure to sustain a burden of rebutting a presumption of reasonableness afforded to said administrative action.

VI

Whether the constitutional guarantee of Due Process of Law is violated where those charged by statute with "establishing" Hospital Service Corporation reimbursement rates abrogate their function by allowing the Hospital Service Corporation and hospitals to determine the elements of costs to be considered in the reimbursement formula, resulting in "admittedly inadequate" reimbursement rates, and consequential de facto subsidization of the Hospital Service Corporation program by all cash paying patients.

QUESTIONS AND STATUTES INVOLVED

The constitutional and statutory provisions involved are: Fourteenth Amendment to the Constitution of the United States; Article 1, par. 1 of the New Jersey Constitution of 1947; Article 1, par. 6, 7, 8, 9 of the New Jersey Constitution of 1947; Article 1 §20 of the New Jersey Con-

stitution of 1947; N.J.R.S. 17:48-1 et seq.; N.J.R.S. 26-2H-18; N.J.R.S. 52:14B-1 et seq.; 29 United States Code §147 et seq.; New Jersey Administrative Code 8:31-14.4; New Jersey Court Rules 4:10-2, and 4:46-1 et seq.

STATEMENT OF THE CASE

Petitioners are individual members and trustees of a union welfare fund. Said Petitioners filed suit on behalf of themselves, and also as a class action on behalf of all labor union welfare funds in the State of New Jersey which provide hospital service benefits not funded through Hospital Service Corporations. (Hereinafter "Blue Cross").

The factual basis of Petitioners complaint is that the Blue Cross reimbursement rates agreed to by Blue Cross and the Respondent Hospitals, and approved by the Commissioners of Health and Insurance, by which Blue Cross reimburses hospitals for health care services rendered to Blue Cross subscribers, are lower than the actual cost of such services. In order to make up the deficit, (as admitted by the hospitals) the hospitals then must, and do, charge non-Blue Cross patients higher rates (above the actual costs of services incurred by the non-Blue Cross patients) with the result that payments of these higher rates by such patients (which include Petitioners) actually subsidize the Blue Cross program.

This action was commenced in the Superior Court of New Jersey, Chancery Division, where the case was bifurcated as a result of a successful application by Respondent Commissioners, to transfer said action as against them, to the Appellate Division of the Superior Court inasmuch as the matter in controversy (the computation of the Blue Cross reimbursement rates) was said to be the final determination of an administrative agency and rendering

same appropriate for resolution by the Appellate Court pursuant to N.J.C.R. 2:2-3(a).

Prior thereto, the Respondent hospitals and Blue Cross had successfully moved before the Chancery Court to dismiss the Complaint as against them pursuant to N.J.C.R. 4:6-2, for failure to state a claim upon which relief could be granted (the Chancery Court treated said motion as one for summary judgment, (122 N.J. Super 387, 392 Ch. 1973)).

The Respondent hospitals and Blue Cross conceded that Respondent Commissioners omit from consideration some of the costs necessary to the operation of hospitals when computing the per diem Blue Cross reimbursement rates. One of the costs so omitted is the cost of indigent care. The Respondent hospitals and Blue Cross affirmatively stated in the Appellate Division that, as a result of the costs omitted from consideration, the hospitals incur financial deficits for facilities and services furnished to Blue Cross subscribers, and that as a further result thereof, said hospitals are required to "recapture" the necessary operating costs so omitted by charging Petitioners, and all others similarly situated, at rates in excess of the actual costs incurred by Petitioners, resulting in a de facto subsidization of Blue Cross subscribers.

Petitioners contend that the aforesaid de facto subsidization is effected by the maintenance of an arbitrary, unreasonable and discriminatory bifurcated rate schedule having a differential known to be at least 20% (see 122 N.J. Super. 387, 394 Ch. 1973). Indeed, the Respondent hospitals specifically reserved the right to bring their own action against the Respondent Commissioners by reason of the "admittedly inadequate" Blue Cross reimbursement rates "at an appropriate time." (See *Borland v. Bayonne Hospital*, RAb 17-29 to 32.)

Thoughout these proceedings the Petitioners have contended that the aforesaid de facto subsidization by them and all others similarly situated of the Blue Cross program, as effected through a bifurcated rate schedule having a differential of no less than 20% (Petitioners were precluded from ascertaining the true extent of the differential), is violative of the Fourteenth Amendment to the Constitution of the United States as well as Article I, par. 1, 7, 8, 9, 19 and 20 of the New Jersey Constitution of 1947.

In a contemporaneous action commenced by some of the same Respondent hospitals in the matter *sub judice*, the Superior Court of New Jersey (Appellate Division), determined that the 1975 Blue Cross reimbursement rates promulgated by the Respondent Commissioners are violative of the Administrative Procedure Act (*N.J.S.A.* 52:14b-1 *et seq.*). See *Monmouth Medical Center et al. v. State of New Jersey, et al.*, Docket No. A-2147-74 to A-2151-74 (unreported).

In *Monmouth* the Court ordered the Respondent Commissioners to hold a hearing with respect to the 1975 Hospital Rate Review Program. Said hearing was held June 11, 1975 at which time a representative of Respondent Commissioner of Health testified that until 1974 there were no material regulations approved to implement a state regulatory system for either rate reporting or rate setting (Petitioners' action was commenced in 1972).

Although the Respondent Commissioners, since 1974, allegedly take a more active role in "approving" per diem rembursement rates, the Commissioners to date, still abrogate their most important legislatively delegated power by continuing to permit Respondents Blue Cross and the Hospitals to determine which elements of cost are "inappropriate" for such reimbursement, and therefore, to be excluded from "total operating costs," (by contract) leaving for themselves the mere ministerial function of rate computation based on said elements. Petitioners contend that statutory purpose and design require, at a minimum, a per diem rate of reimbursement paid by Blue Cross to enable the hospitals to "break even" on the costs of providing medical care to Blue Cross subscribers. However, Respondent hospitals stated below that the rate of differential of per diem reimbursement under the bifurcated fee schedules was required as

> "the performance of their fiduciary duty requires hospital trustees to charge rates to the general public which will insure a solvent hospital and a balanced budget (Rab). *As a result the rates hospitals charge others, including plaintiffs, is computed to permit the hospitals to recapture their omitted costs.* The difference in rates is said to approximate twenty (20%) per cent.

On August 15, 1975, Notice of Appeal to the Supreme Court of New Jersey was filed in both cases (Appendix 130a and 131a).

On January 13, 1977, the New Jersey Supreme Court affirmed the judgments of the courts below (Addendum "A" at 18).

REASONS FOR GRANTING WRIT

1. The determination of the courts below that Respondents' administration of a tripartite statutory scheme, resulting in a de facto subsidization of Respondent Blue Cross is constitutionally permissible, does not comport with the precedents of this court. *Reagan v. Farmers Loan & Trust Company*, 154 U.S. 362, 397, 38 L.ed., 1014-1923, 14 S. Ct., 1047 (1894). Respondents concede that there is a differential in the per diem rate of hospital reimbursement paid by Petitioners and that paid by Respondent Blue Cross. The elements of cost which comprise the differential in the bifurcated per diem rates were never fully disclosed to the Court or to Petitioners. Nonetheless, the Chancery Court determined that there was no necessity for a plenary hearing to determine the precise items of cost omitted from consideration by Respondent Commissioners, (see 122 N.J. Super. 387, 395 (Ch. 1973)) since Respondents conceded the existence of a differential in per diem rates approximating twenty (20%) per cent. Nevertheless, Petitioners submit that they were denied Due Process of Law since they were precluded from utilizing the tools of discovery to support their contention that the elements of costs which result in the rate differential were arbitrarily eliminated by Respondent Commissioners in computing the per diem rate of reimbursement. The statutory scheme envisioned by the legislature, requires said Commissioners to consider the total costs necessary to maintain solvency of Respondent hospitals. Therefore, the per diem rate of reimbursement paid by Respondent Blue Cross for services rendered to its subscribers must be equivalent to the cost of medical services rendered to them.

Before the Courts below, Respondent hospitals consistently took the position that the Blue Cross rates set by Respondent Commissioners resulted in operating losses

because those rates did not meet the actual cost of medical services rendered to Blue Cross subscribers. Consequently, Respondent hospitals stated that:

> "the performance of their fiduciary obligations requires hospital trustees to charge rates to the general public which will insure a solvent hospital and balanced budget (*Borland v. Bayonne* Rab 9-24 to 27).

As a result thereof, Respondent hospitals recoup their omitted costs by charging Petitioners, and those similarly situated, with the "loss" they incur on medical services provided to Blue Cross subscribers. However, Respondent Commissioners did not share the view taken by the hospitals. Having successfully bifurcated Petitioners' cause of action by choosing not to join issue with Respondent hospitals and Respondent Blue Cross before the Chancery Court, Respondent Commissioners took the position before the Appellate Division that the per diem rate of reimbursements, which they "approved" for Respondent Blue Cross, fully compensated Respondent hospitals for the actual cost of medical services and facilities furnished Blue Cross subscribers. Although confronted with this highly disputed genuine issue of material fact, which rendered summary judgment inappropriate, both the Appellate Division and the Supreme Court choose to ignore same by perfunctorily affirming the decision of the Chancery Judge.

Petitioners have been precluded by the courts of New Jersey, from determining the precise elements which comprise the per diem rate of reimbursement paid to Respondent hospitals by Respondent Blue Cross, and have been further precluded from determining the elements of the rate differential (which Respondent Commissioners claim is not attributable to the costs of medical services rendered to Blue Cross subscriber patients), resulting in a discriminatory per diem charge paid by Petitioners for identical medical services.

Petitioners' constitutional attack against the Respondent Commissioners, Blue Cross and the hospitals, is not premised upon the admitted differential in the per diem rate of reimbursement per se, but upon the de facto subsidization of cost elements, which are said to be omitted from the per diem rate of reimbursement paid by the Respondent hospitals through per diem rates of reimbursement charged to Petitioners and others similarly situated. When the control attempted to be exercised over private rights is in excess of that which is essential to effectuate the legitimate exercise of the Police Power, constitutionally protected rights to life, liberty, and property are violated. The Equal Protection Clause applies to every exercise of power by the State which affects the individual and his property, *Louisville Gas & Electric Co. v. Coleman*, 277 U.S. 32, 37, 72 L.Ed. 770, 774, 48 S.Ct. 423 (1918). In the case *sub judice*, Petitioners attack the non-functional de facto discount granted to Respondent Blue Cross which results in the appropriation of Petitioners' property.

It has always been a function of this Court to determine whether an act of one party operates to divest another of a vested right, *Skinner v. Oklahoma*, 316 U.S. 535, 541, 86 L.ed. 1655, 1660, 62 S.Ct. 1110 (1942) *Yick Wo v. Hopkins*, 118 U.S. 356, 30 L.ed. 220, 222, 6 S.Ct 1064 (1886) Enshrined in the Fourteenth Amendment is the prophylactic rule forbidding legislation, or the administration of a legislative scheme, by which the property interests of one individual are wrested from him for the benefit of another or for the public.

> "This, as has been often observed, is a government of law, and not a government of men, and it must never be forgotten that under such a form of government, with its constitutional limitations and guarantees, the forms of law and the machinery of government, with all their reach and power, must in their actual workings stop on the hither side of the unnecessary and uncompensated taking or destruction of any private property, legally acquired and legally held. *Reagan v. Farmers Loan & Trust Co.*, 154 U.S. 362, 399, 38 L.Ed. 1014, 1024, 14 S.Ct. 104) (1894).

2. One of the elements of cost admittedly not computed in the per diem rate of reimbursement paid by Respondent Blue Cross, is the cost of providing indigent medical care. Yet, Respondents state that one of the primary governmental goals and objectives of the legislature in enacting the subject statutes was to help the community carry the social and economic burden created by people who are unable to pay for necessary hospital care rendered at Respondent hospital facilities. Certainly, the validity of a legislative classification premised upon a particular governmental objective, must be said to be arbitrary and unreasonable, where a primary objective of the legislative scheme is usurped by the ultra vires administration of the statute, as where the Respondent Commissioners fail to include the cost of indigent care in computing the per diem reimbursement rate of Respondent Blue Cross, whose subscribers comprise approximately seventy (70%) percent of the population. Secondly, the constitutional validity of a state statutory scheme which exempts a specially created legislative class from sharing the burden of indigent costs could not be said to bear a reasonable relationship to the governmental objective sought to be achieved (i.e. broad based community care). The Equal Protection Clause of the Fourteenth Amendment applies to every person within the jurisdiction of a state regardless of accident of accident of birth, sex, or fortune. *Bell v. Maryland*, 378 U.S. 226, 262, 12 L.Ed. 2d 822, 836, 84 S.Ct. 1814 (1964). It acts as a limitation on the exercise of gov-

ernmental power, *Traux v. Corrigan*, 257 U.S. 312, 340, 66 L.ed. 254, 266, 42 S.Ct. 124 (1921). It demands that every person be protected from governmental action which inhibits its equal treatment under law; both in privileges conferred and liabilities imposed. Immunity granted one class from a liability thrust upon all others, absent a reasonable underlying factual basis, is clearly a denial of equal protection. While equal protection acts upon the assumption that government may recognize and act upon factual differences existing among and between persons, it does not sanction "state action," which inhibits equal treatment under like circumstances. The classification of persons or objects must be reasonable, and this reasonableness must have a rational relationship to a valid governmental purpose, *Tigner v. Texas*, 310 U.S. 141, 147, 84 L.ed. 1124, 1128, 60 S.Ct. 879 (1939); *Graham v. Richardson*, 403 U.S. 365, 371, 29 L.ed. 2d 534, 541, 91 S.Ct., 1848 (1971).

As administered by Respondent Commissioners, the statutory scheme here in question thrusts the burden of indigent care upon Petitioners, and others similarly situated while immunizing a governmentally created class from assuming their proportionate share of the economic burden of providing indigent medical care.

> "The Constitution was framed under the diminion of a political philosophy less parochial in range. It was framed upon the theory that the peoples of the several states must sink or swim together, and that in the long run, prosperity and salvation are in *union* and not in *division*. *Baldwin v. G.A.F. Sealing, Inc.*, 294 U.S. 511, 523, 79 L.ed. 1032, 1038, 55 S.Ct. 497 (1921).

3. Petitioners contend that the de facto subsidization of Respondent hospitals, through confiscatory per diem reimbursement rates, interferes with "fundamental rights," requiring the proponents of the statutory scheme to demonstrate the existence of a compelling state interest.

The right to property in a free society is a fundamental right expressly guaranteed by the Fourteenth Amendment. Where fundamental rights are involved the mere showing that a classification is rational will not withstand a constitutional challenge. As presently administered, the statutory scheme in question omits certain cost elements which are necessary to the operation of medical facilities and rendition of health care services, resulting in lost revenues to Respondent hospitals. As a consequence thereof, Respondent hospitals state that they are compelled to charge the general public rates that will insure solvent hospitals. This process of confiscatory reimbursement infringes upon Petitioners' fundamental right to property, as said confiscatory scheme is violative of substantive due process of law.

> "the constitutional prohibition against the deprivation of property without due process of law reflects the high value imbedded in constitutional and political history, that is placed on a person's right to enjoy what is his, free of governmental interference. *Fuentes v. Shavin*, 407 U.S. 67, 81, 32 L.ed 2d 556, 570, 92 S.Ct. 1983 (1972).

4. Petitioners where denied procedural due process in not being allowed to proceed to a plenary hearing, with accompanying discovery by the courts below, so that the true processes by which Respondent Blue Cross reimbursement rates are established could be ascertained.

It is the very essence of Petitioner's position that for purposes of a proper adjudication of their claim, they were entitled to make use of the tools of discovery as set out in the Rules Governing the Courts of New Jersey (N.J.C.R. 4:10-2).

In order to adjudicate Petitioners' constitutional challenge, the lower courts were required to determine the "reasonableness" of those elements excluded from the per diem Blue Cross rates of reimbursement. There can be no doubt as to the Court's power and duty to inquire whether

a schedule of rates is so unreasonable and so unjust, that in practical application, they work to destroy the fundamental right to property guaranteed by the Constitution.

Petitioners submit that in order for the courts below to determine whether the per diem rate structure employed by Respondent hospitals and Blue Cross was discriminatory, it was essential that the elements of the per diem rate be identified and evaluated.

In considering Petitioners constitutional challenge, the lower courts were content to deal solely with the issue of "reasonableness" of the Blue Cross classification vis-a-vis its relationship to a valid governmental purpose, and did not consider the infringement upon Petitioners' fundamental rights which results through the actual administration of the statutory scheme.

Petitioners submit that the lower courts erred in this regard, and in so doing denied Petitioners due process of law. *First*, because the Commissioners had no material regulations for determining the elements of the Blue Cross rate. *Secondly*, because the Commissioners do not determine "total cost," as they limit themselves to the elements found in the Contracting Hospital Agreements which are negotiated by Respondent Blue Cross and the hospitals, thus abrogating and ignoring their statutory duty. *Third*, because a resolution of the constitutional challenge raised by Petitioners to the actual administration of this statutory scheme, demands identification and an evaluation of the excluded items of cost, to determine the appropriateness of their inclusion or exclusion, and ultimately the reasonableness of the confiscatory rate charged to Petitioners, and others similarly situated.

CONCLUSION

For the foregoing reasons, petitioners pray that their petition for an issuance of a writ of Certiorari be granted.

Respectfully submitted,

HAROLD KRIEGER
Counsel for Petitioners

/s/ Harold Krieger
HAROLD KRIEGER

FERRARA & FEINSILVER
Of Counsel on the Petition

ADDENDUM "A"

OPINION OF THE SUPREME COURT OF NEW JERSEY (REPORTED AT 72 N.J. 152)

JOHN BORLAND, JR., J. BARRON LEEDS, LOUIS POLEVOY, IRVING KAPLAN, IRVING LEVY, JOHN NICCOLLAI, AS TRUSTEES OF THE WELFARE FUND OF LOCAL 464, AMALGAMATED MEAT CUTTERS FOOD STORE, EMPLOYEES UNION, AFL-CIO AND HOWARD MARKS, PLAINTIFFS-APPELLANTS, v. BAYONNE HOSPITAL, BERGEN PINES COUNTY HOSPITAL, BETH ISRAEL HOSPITAL, CLARA MAASS MEMORIAL HOSPITAL, ENGLEWOOD HOSPITAL ASSOCIATION, GREATER PATERSON GENERAL HOSPITAL, HACKENSACK HOSPITAL, IRVINGTON GENERAL HOSPITAL, HOLY NAME HOSPITAL, THE HOSPITAL CENTER AT ORANGE, MONMOUTH MEDICAL CENTER, MORRISTOWN MEMORIAL HOSPITAL, MOUNTAINSIDE HOSPITAL, NEWARK BETH ISRAEL MEDICAL CENTER, RIVERDELL HOSPITAL, SADDLE BROOK HOSPITAL, SAINT BARNABAS MEDICAL CENTER, ST. MICHAEL'S MEDICAL CENTER, SOUTH AMBOY MEMORIAL HOSPITAL, ST. JOSEPH'S HOSPITAL, ST. MARY'S HOSPITAL OF HOBOKEN, ST. MARY'S HOSPITAL OF PASSAIC, THE BLUE CROSS-BLUE SHIELD PLAN OF NEW JERSEY, A CORPORATION OF THE STATE OF NEW JERSEY, DEFENDANTS-RESPONDENTS.

JOHN BORLAND, JR., J. BARRON LEEDS, LOUIS POLEVOY, IRVING KAPLAN, IRVING LEVY, JOHN NICCOLLAI, AS TRUSTEES OF THE WELFARE FUND OF LOCAL 464, AMALGAMATED MEAT CUTTERS FOOD STORE, EMPLOYEES UNION, AFL-CIO AND HOWARD MARKS, PLAINTIFFS-APPELLANTS v. RICHARD McDONOUGH, COMMISSIONER OF INSURANCE OF THE STATE OF NEW JERSEY, AND JAMES R. COWAN, M.D., COMMISSIONER OF HEALTH OF THE STATE OF NEW JERSEY, DEFENDANTS-RESPONDENTS.

Argued November 22, 1976—Decided January 13, 1977.

SYNOPSIS

Action was brought to contest allegedly discriminatory hospital rates. The Superior Court, 122 *N. J. Super.* 387, granted summary judgment in favor of defendant hospitals and hospital service corporation, and plaintiffs appealed. The Superior Court, Appellate Division, 136 *N. J. Super.* 60, affirmed, and, 135 *N. J. Super.* 200, affirmed decision of Commissioners of Insurance and Health approving reimbursement rates, and plaintiffs appealed. The Supreme Court, Sullivan, J., held that statutory scheme had sufficient standards to control administrative approval of rates by which hospital service corporation reimbursed hospitals for services rendered its subscribers and that, applying such standards, rational basis had been demonstrated for exclusion of operating expenses in question from computation of rates; and that regulation of reimbursement rates paid by hospital service corporation, which was open for membership to general public, was not only reasonable and in furtherance of state public policy in field of public health care but was consonant with equal protection to all hospital users.

Affirmed.

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1. Constitutional law key 318(2)

Where record as expanded set forth in detail procedure and method of computation by which hospital, service corporation's reimbursement rates were fixed, there was adequate exposure of statutory scheme, and plaintiffs' major contention that reimbursement rates for services rendered corporation's subscribers were lower than hospital rates charged nonsubscribers was conceded, plaintiffs were not denied due process by not being allowed to proceed to plenary hearing to further illuminate processes by which reimbursement rates were established. *N. J. S. A.* 17:48-7, 26:2H-18.

2. Hospitals key 3

Plaintiffs, who were challenging reimbursement rates agreed to by hospital service corporation and hospitals and approved by Commissioners of Health and Insurance for health care services rendered corporation's subscribers, but who failed to show that adjustments by which certain operating expenses of hospitals were excluded in computing reimbursement rates were arbitrary or unreasonable in view of distinction made by statutes and regulations between hospital service corporations open to general public, other health plans, and general public, failed to sustain their burden of rebutting presumption as to reasonableness of administrative action. *N. J. S. A.* 17:48-7, 26:2H-18.

3. Hospital key 3

Statutory scheme under which reasonableness of reimbursement rates for services rendered subscribers of hospital service corporation were approved contained sufficient standards to control administrative approval process and, applying such standards, rational basis was demonstrated for exclusion of operating expenses from computation of

reimbursement rates which either did not involve services rendered subscribers, were items of expenses for which recovery was had from other sources, or were not for services for which corporation was billed at a different rate. *N. J. S. A.* 17:48-7, 9, 26:2H-18.

4. Constitutional law key 240(1)

Hospital key 3

Hospital service corporation, which was open for membership to general public, was sufficiently distinguishable from other health care plans and general public so that its different treatment in connection with computation of reimbursement rates paid hospitals for health care services rendered its subscribers was not arbitrary nor a denial of equal protection even though reimbursement rates fixed were lower than hospital rates charged nonsubscribers, and thus approved of reimbursement rates not only was reasonable and in furtherance of stated policy in field of public health care but was consonant with equal protection to all hospital users. *N. J. S. A.* 17:48-7, 26:2H-18.

Mr. Harold Krieger argued the cause for appellants (*Messrs. Krieger & Chodash*, attorneys).

Mr. Bruce D. Shoulson argued the cause for respondent hospitals and Hospital Service Plans of New Jersey (*Messrs. Lowenstein, Sandler, Brochin, Kohl & Fisher*, attorneys for Newark Beth Israel Medical Center; *Messrs. Winne & Banta*, attorneys for Hackensack Hospital Association; *Messrs. Lebson & Prigoff*, attorneys for Englewood Hospital Association; *Messrs. Johnson, Johnson & Murphy*, attorneys for St. Joseph's Hospital and Medical Center; *Messrs. Schenck, Price, Smith & King*, attorneys for Morristown Memorial Hospital; *Messrs. Booth, Bate, Hagoort, Keith & Harris*, attorneys for Mountainside Hospital; *Messrs. Riker, Danzig, Scherer & Debevoise*, attorneys for The Hospital

Center at Orange and St. Barnabas Medical Center; *Messrs. Wilentz, Goldman & Spitzer*, attorneys for South Amboy Memorial Hospital; *Messers. Pitney, Hardin & Kipp*, attorneys for Hospital Service Plan of New Jersey; *Messrs. McCann and McCann*, attorneys for Saddle Brook General Hospital; *Messrs. Mandak, Roth & Ferrante*, attorneys for St. Mary's Hospital of Passaic; *Messrs. Smith, Kramer & Morrison*, attorneys for Clara Maass Memorial Hospital; *Messrs. Kein, Pollatschek & Iacopino*, attorneys for Irvington General Hospital; *Messrs. Milton, Keane & Brady*, attorneys for St. Michael's Medical Center and St. Mary's Hospital of Hoboken; *Mr. Vincent P. Rigolosi*, Bergen County Counsel, attorney for Bergen Pines County Hospital; *Messrs. Morrison & Griggs*, attorneys for Greater Paterson General Hospital; *Messrs. Clapp & Eisenberg*, attorneys for Riverdell Hospital; *Messrs. Giordano & Halleran*, attorneys for Monmouth Medical Center; *Mr. Elmer Friedbauer*, attorney for Beth Israel Hospital of Passaic; *Messrs. Breslin and Breslin*, attorneys for Holy Name Hospital).

Mr. Wesley S. Caldwell, III, Deputy Attorney General, argued the cause for respondent Commissioners of Insurance and Health of New Jersey (*Mr. William F. Hyland*, Attorney General of New Jersey, attorney).

The opinion of the court was delivered by

SULLIVAN, J. The summary judgment in favor of defendant Hospitals and defendant Hospital Service Plan of New Jersey (hereinafter Blue Cross) is affirmed for the reasons expressed by Judge Fink of the Chancery Division in his opinion reported at 122 *N. J. Super.* 387 (1973), aff'd o. b. 136 *N. J. Super.* 60 (App. Div. 1975) Also, the judgment in favor of the Commissioner of Health of the State of New Jersey and the Commissioner of Insurance of the State of New Jersey is affirmed for the reasons given by the Appellate Division in its opinion reported in *Borland v. McDonough*, 135 *N. J. Super.* 200 (1975). We add the following comments to those opinions.

Plaintiffs appealed to this Court as of right, *R.* 2:2-1(a)(1), alleging a violation of their constitutional rights. Essentially they contend that they were denied procedural due process in not being allowed to proceed to a plenary hearing, with accompanying discovery, in which the true processes by which Blue Cross reimbursement rates to defendant Hospitals are established could be further illuminated. They also claimed a denial of substantive due process in a statutory scheme which, in the absence of a compelling state interest, results in a confiscatory taking of plaintiffs' property. Finally, they argue that the same statutory scheme lacks sufficient standards so as to amount to an unconstitutional delegation of legislative power and, as administered and implemented, is not rationally related to a proper governmental purpose and denies them equal protection under law.

The alleged factual basis for these contentions is that the rates agreed to by Blue Cross and defendant Hospitals, and approved by the Commissioners of Health and Insurance, by which Blue Cross reimburses the hospitals for health care services rendered to Blue Cross subscribers are lower than the actual cost of such services. In order to make up the deficit, the hospitals then must charge non-Blue Cross patients higher rates with the result that payments of these higher rates by such patients (which include plaintiffs) actually subsidize the Blue Cross program.

[1] Plaintiffs' contention that they are entitled to a plenary hearing to develop their factual case is not convincing. The record, as expanded, sets forth in detail the procedure and method of computation by which Blue Cross reimbursement rates are fixed. We have an adequate exposure of the statutory scheme as administered and implemented. See *N. J. S. A.* 17:48-7; *N. J. S. A.* 26:2H-18. Plaintiffs' major factual contention—that the rates fixed by the Commissioners of Health and Insurance by which Blue

Cross reimburses defendant Hospitals for services rendered Blue Cross subscribers are lower than the rates charged plaintiffs and other non-Blue Cross subscribers—is conceded.

[2] Nor are plaintiffs other factual assertions supported by the record to any substantial degree. It appears that the rates by which Blue Cross reimburses the hospitals for services rendered Blue Cross subscribers are based on a method of computation which excludes specified operating expenses of the hospitals. However, the excluded expenses either do not involve services rendered Blue Cross subscribers, are items of expense for which recovery is had from other sources, or are not for services for which Blue Coss is billed at a different rate.[1] The method of calculation does take into–consideration the total expenses of the hospital even though it allows for adjustments in computing the cost of health care service for Blue Cross subscribers not necessarily allowed in the charges to non-subscribers. These adjustments have not shown to be arbitrary or unreasonable insofar as the pertinent statutes and regulations distinguish between hospital service corporations open to the general public, such as Blue Cross, and other health plans restricted in their membership and coverage, and the general public not members of any health plan. There is a strong presumption as to the reasonableness of administrative action. One attacking such action has the burden of rebutting this presumption. Plaintiffs have failed to sustain this burden.

Blue Cross, organized pursuant to *N. J. S. A.* 17:48-1 *et seq.* complements the public health care program of this State. It has established and operates a hospital service plan whereby comprehensive health care services are made

1. For example, the cost of research programs subsidized by special grants is excluded as are the costs of out-patient care since Blue Cross is charged the same rates for such care as is charged to non-subscribers.

available on a non-profit basis. The plan is open to the public (including plaintiffs') as provided by statute. Such an organization and its operation clearly are affected with a public interest.

[3] The declared public policy of this State is that health care services "of the highest quality, of demonstrative need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health." *N. J. S. A.* 26:2H-1. The Legislature, as a means of achieving the goal of "reasonable cost," has empowered the Commissioners of Health and Insurance, after taking into consideration the total costs of the health care facility, to approve the "reasonableness" of the rates by which Blue Cross reimburses hospitals for services rendered its subscribers.[2] This legislative enactment does contain sufficient standards to control the administrative approval process. Applying such standards, a rational basis has been demonstrated for the exclusion of the operating expenses in question.

Plaintiffs also contend that they are denied due process and equal protection by a statutory program which regulates the reimbursement rates paid to hospitals for health care services rendered to Blue Cross subscribers, but makes no provision for regulation of the charges made by hospitals to the general public (including plaintiffs). The result, say plaintiffs, is that non-Blue Cross patients are charged more and pay more for the same health care services.

However, such a differential in hospital rates becomes invidious only if it is shown that the classification from which the rate differential stems does not bear a reasonable relation to a permissible legislative objective. In *David v. Vesta Co.*, 45 N. J. 301, 315 (1965), we held that:

2. The rates which Blue Cross charges its subscribers for health care coverage are also regulated by statute and must be approved by the Commissioner of Insurance. See *N.J.S.A.* 17:48-9. These rates obviously reflect what Blue Cross must pay for health care services rendered its subscribers.

> "• • • The constitutionality of a legislative classification is presumed, and one who assails the classification must carry the burden of showing its arbitrariness. A classification having some reasonable basis is not invalid merely because it is not made with mathematical nicety or because in practice it results in some inequality. And the classification must be upheld if any set of facts can reasonably be conceived to support it. In short, the equal protection clause forbids only invidious discrimination. • • •"

[4] This principle is directly applicable to the situation here presented. We find hospital service corporations open for membership to the general public to be a sufficiently distinguishable category from other health care plans and from that of the general public, not members of any health plan, such that their different treatment in the respect here involved cannot be said to be arbitrary or to deny equal protection. We therefore find the regulation of reimbursement rates paid by a hospital service corporation not only to be reasonable and in furtherance of the stated public policy of this State in the field of public health care, but to be consonant with equal protection to all hospital users. Such regulation is reflected in the rates which Blue Cross is allowed to charge its subscribers to the end that health care protection be made available to the public at a reasonable cost. The judgments applied from are affirmed.

For affirmance—Chief Justice HUGHES, Justices MOUNTAIN, SULLIVAN and PASHMAN and Judge CONFORD—5.

For reversal—None.

ADDENDUM "B"
PENITENT NEW JERSEY STATUTES AND RULES

26:2H-1. Declaration of policy

It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the "Comprehensive Health Planning and Public Health Services Amendments of 1966" (Federal Law 89-749), as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as boarding, nursing or maternity homes or other homes for the sheltered care of adult persons or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

26:2H-2. Definitions

The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diag-

nosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic care agency, boarding home or other home for the sheltered care of adult persons and bioanalytical laboratory or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer.

b. "Health care service" means the preadmission, outpatient, in-patient and post-discharge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice or by practitioners of healing solely by prayer. . . .

26:2H-18. Payments by government agency or hospital service corporation; determination of rates

a. No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

17:48-1. Definitions

A hospital service corporation is hereby declared to be any corporation organized, without capital stock and not for profit, for the purpose of establishing, maintaining and operating a nonprofit hospital service plan. A hospital service plan is hereby defined as a plan whereby hospital service in health care services are provided by a hospital service corporation or by a hospital or institution health care facility with which the corporation has a contract for such hospital service health care services to persons who become subscribers under contracts with the corporation. Hospital service Health care services provided by a hospital service corporation shall consists of hospital include health care provided (a) through a hospital or institution health care facility which is maintained by a State or any of its political subdivisions; (b) through a hospital or insti-

tution health care facility licensed by the Department of Institutions and Agencies Department of Health; (c) through such other hospitals and institutions, health care facilities as shall have been designated by the Department of Institutions and Agencies Department of Health for hospital care health care servics; (d) through hospitals and institutions, health care facilities located in other states, which are subject to the supervision of such other States provided that such last mentioned hospitals and institutions, health care facilities, if they were located in this State, would be eligible to be licensed or designated by the Department of Institutions and Agencies Department of Health; (e) through nonprofit hospital service plans of other States approved by the Commissioner of Banking and Insurance.

17:48-1.7 Additional powers; contract benefits; disapproval by commissioner; review

Any hospital service corporation organized pursuant to the laws of this State, in addition to other powers conferred upon it, shall be authorized and empowered to include in its contracts benefits not only for hospital services but also benefits for such other related similar health care services and supplies or health care services or supplies other than the services of persons licensed to practice medicine or surgery for any and all employees of an employer and which benefits have been agreed upon by such employer and a union, and which as are approved for such inclusion by the Commissioner of Banking and Insurance. The commissioner may disapprove any contract which makes provision for such health care services and supplies or health care services or supplies if it provides for a type of coverage or contains other provisions which he determines to be unrelated health care services or unjust, unfair, inequitable, misleading, or contrary to law. All determinations of the commissioner under this section shall be subject to review by the Superior Court in a proceeding in lieu of a prerogative writ.

17:48-6. Contracts; certificates; contents

Every individual contract made by a corporation subject to the provisions of this chapter to furnish services to a subscriber shall provide for the furnishing of services for a period of 12 months, and no contract shall be made providing for the inception of such services at a date later than 1 year after the actual date of the making of such contract. Any such contract may provide that it shall be automatically renewed from year to year unless there shall have been at least 30 days prior written notice of termination by

(d) A statement that the contract includes the endorsements thereon and attached papers, if any, and contains the entire contract for services;

(c) A statement that no statement by the subscriber in his application for a contract shall avoid the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract, and that no agent or representative of such corporation, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions;

(f) A statement that if the subscriber defaults in making any payment under the contract, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the contract, but with respect to sickness and injury may cover such sickness as may be first manifested more than 10 days after the date of such acceptance;

(g) A statement of the period of grace which will be allowed the subscriber for making any payment due under the contract. Such period shall be not less than 10 days.

In every such contract made, issued or delivered in this State:

(a) All printed portions shall be plainly printed in type of which the face is not smaller than 10 point;

(b) There shall be a brief description of the contract on its first page and on its filing back in type of which the face is not smaller than 14 point;

(c) The exceptions of the contract shall appear with the same prominence as the benefits to which they apply; and

(d) If the contract contains any provision purporting to make any portion of the articles, constitution or by-laws of the corporation a part of the contract, such portion shall be set forth in full.

52:14B-1. Short title

This act shall be known and may be cited as the "Administrative Procedure Act."
L.1968, c. 410, § 1, eff. Sept. 1, 1969.

52:14B-2. Definitions

As used in this act:

(a) "State agency" or "agency" shall include each of the principal departments in the executive branch of the State Government, and all boards, divisions, commissions, agencies, departments, councils, authorities, offices or officers within any such departments now existing or hereafter established and authorized by statute to make, adopt or promulgate rules or adjudicate contested cases, except the

office of the Governor, the Division of Workmen's Compensation in the Department of Labor and Industry, the Department of Defense, and any boards, divisions, commissions, councils, agencies, departments, authorities, offices or officers therein, and all agencies the primary responsibility of which is the management or operation of a State educational, medical, mental, rehabilitative, custodial, penal or correctional institution or program, insofar as the acts of such agency relate to the internal affairs of such institution or program.

(b) "Contested case" means a proceeding, including any licensing proceeding, in which the legal rights, duties, obligations, privileges, benefits or other legal relations of specific parties are required by constitutional right or by statute to be determined by an agency by decisions, determinations, or orders, addressed to them or disposing of their interests, after opportunity for an agency hearing.

(c) "Administrative adjudication" or "adjudication" includes any and every final determination, decision or order made or rendered in any contested case.

(d) "The head of the agency" means and includes the individual or group of individuals constituting the highest authority within any agency authorized or required by law to render an adjudication in a contested case.

(e) "Administrative rule" or "rule," when not otherwise modified, means each agency statement of general applicability and continuing effect that implements or interprets law or policy, or describes the organization, procedure or practice requirements of any agency. The term includes the amendment or repeal of any rule, but does not include: (1) statements concerning the internal management or discipline of any agency; (2) intra-agency and inter-agency statements; and (3) agency decisions and findings in contested cases.

(f) "License" includes the whole or part of any agency license, permit, certificate, approval, chapter, registration or other form of permission required by law.

(g) "Secretary" means the Secretary of State.

(h) "Director" shall mean the Director of the Division of Administrative Procedure, unless otherwise indicated by context.

52:14B-3. Additional rule-making requirements

In addition to other rule-making requirements imposed by law, each agency shall:

(1) adopt as a rule a description of its organization, stating the general course and method of its operations and the methods whereby the public may obtain information or make submissions or requests;

(2) adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available, including a description of all forms and instructions used by the agency;

(3) make available for public inspection all final orders, decisions, and opinions, in accordance with the provisions of chapter 73 of the laws of 1963 as amended and supplemented (c. 47:1A-1 et seq.)

52:14B-4. Notice and hearing

(a) Prior to the adoption, amendment, or repeal of any rule, except as may be otherwise provided the agency shall:

(1) Give at least 20 days' notice of its intended action. The notice shall include a statement of either the terms or substance of the intended action or a description of the subjects and issues involved, and

the time when, the place where, and the manner in which interested persons may present their views thereon. The notice shall be mailed to all persons who have made timely request of the agency for advance notice of its rule-making proceedings and in addition to other public notice required by law shall be published in the New Jersey Register;

(2) Afford all interested persons reasonable opportunity to submit data, views, or arguments, orally or in writing. The agency shall consider fully all written and oral submissions respecting the proposed rule.

(b) A rule prescribing the organization or procedure of an agency may be adopted at any time without prior notice or hearing. Such rule shall be effective upon filing in accordance with section 5 of this act or upon any later date specified by the agency.

(c) If an agency finds that an imminent peril to the public health, safety, or welfare requires adoption of a rule upon fewer than 20 days' notice and states in writing its reasons for that finding, it may proceed without prior notice or hearing or upon any abbreviated notice and hearing that it finds practicable, to adopt the rule.

(d) No rule hereafter adopted is valid unless adopted in substantial compliance with this section. A proceeding to contest any rule on the ground of noncompliance with the procedural requirements of this section must be commenced within 1 year from the effective date of the rule.

52:14B-8. Declaratory rulings

Subject to the provisions of section 4(b) and 4(e) of chapter 20, laws of 1944, as amended and supplemented (C. 52:17A-4b and 4e), an agency upon the request of any

interested person may in its discretion make a declaratory ruling with respect to the applicability to any person, property or state of facts of any statute or rule enforced or administered by that agency. A declaratory ruling shall bind the agency and all parties to the proceedings on the state of facts alleged. Full opportunity for hearing shall be afforded to the interested parties. Such ruling shall be deemed a final decision or action subject to review in the Appellate Division of the Superior Court. Nothing herein shall affect the right or practice of every agency in its sole discretion to render advisory opinions.

52:14B-9. Notice and hearing in contested cases

(a) In a contested case, all parties shall be afforded an opportunity for hearing after reasonable notice.

(b) The notice shall include in addition to such other information as may be deemed appropriate:

(1) A statement of the time, place, and nature of the hearing;

(2) A statement of the legal authority and jurisdiction under which the hearing is to be held;

(3) A reference to the particular sections of the statutes and rules involved;

(4) A short and plain statement of the matters asserted. If the agency or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter upon application a more definite and detailed statement shall be furnished.

(c) Opportunity shall be afforded all parties to respond, appear and present evidence and argument on all issues involved.

(d) Unless precluded by law, informal disposition may be made of any contested case by stipulation, agreed settlement, or consent order.

(e) Oral proceedings or any part thereof shall be transcribed on request of any party at the expense of such party.

(f) Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

(g) Unless otherwise provided by any law, agencies may place on any party the responsibility of requesting a hearing if the agency notifies him in writing of his right to a hearing and of his responsibility to request the hearing.

NEW JERSEY COURT RULES

2:2-3. Appeals to the Appellate Division from Final Judgments, Decisions, Actions and from Rules

(a) As of Right. Except as otherwise provided by R. 2:2-1(a) (3) (final judgments, appealable directly to the Supreme Court), appeals may be taken to the Appellate Division as of right (1) from final judgments of the Superior Court trial divisions, the county court or the judges thereof sitting as statutory agents; the juvenile and domestic relations courts except in bastardy and paternity proceedings; the county district courts in civil actions except bastardy and paternity proceedings; and in summary contempt proceedings in all trial courts except municipal courts; (2) to review final decisions or actions of any state administrative agency or officer except those governed by R. 4:74-8 (Wage Collection Section appeals), or to review the validity of any rule promulgated by such agency or officer; (3) in such cases as are provided by law. Unless the interest of justice requires otherwise, review pursuant to R. 2:2-3(a) (2) shall not be maintainable so long as there is available a right of review before any administrative agency or officer.

(b) Time: Effect of Certain Motions. Unless the court fixes a different time period, the time periods prescribed in paragraph (a) of this rule are altered by the filing and service of a motion under R. 4:6 or for summary judgment under R. 4:46 or R. 4:69-2 as follows: (1) if the motion is denied in whole or part or its disposition postponed until trial, the responsive pleading shall be served within 10 days after notice of the court's action; (2) if a motion for a more definite statement is granted, the responsive pleadings shall be served within 10 days after the service of such statement. If notice is given a

nonresident party demanding security for costs and the nonresident gives notice of the filing of the bond or the making of the deposit, the party making the demand shall then have the same time to plead as may have remained at the time of the service of the notice demanding the security.

4:46-1. Time of Motion

A party seeking any affirmative relief, including a declaratory judgment may, at any time after the expiration of 20 days from the service of his pleading claiming such relief, or after service of a motion for summary judgment by the adverse party, move for a summary judgment or order in his favor upon all or any part thereof or as to any defense. A party against whom a claim for such affirmative relief is asserted may move at any time for a summary judgment or order in his favor as to all or any part thereof.

4:46-2. Motion and Proceedings Thereon

The motion for summary judgment shall be served with briefs and with or without supporting affidavits. The judgment or order sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact challenged and that the moving party is entitled to a judgment or order as a matter of law. The court shall find the facts and state its conclusions in accordance with R. 1:7-4. A summary judgment or order, interlocutory in character may be rendered on any issue in the action (including the issue of liability) although there is a genuine factual dispute as to any other issue (including any issue as to the amount of damages). Subject to the provisions of R. 4:42-2 (judgment upon multiple claims), a summary judgment final in character may be rendered in respect of any portion of the damages claimed.

4:46-3. Case Not Fully Adjudicated on Motion

If on motion under this rule judgment is not rendered upon the whole action or for all the relief asked and a trial is necessary, the court at the hearing of the motion, by examining the pleadings and the evidence before it and by interrogating counsel, shall, if practicable, ascertain what material facts, including facts as to the amount of damages, exist without substantial controversy and shall thereupon make an order specifying those facts and directing such further proceedings in the action as are appropriate. Upon trial of the action the facts so specified shall be deemed established.

4:46-4. Leave to Proceed Upon Terms

Leave to proceed may be given unconditionally, or upon such terms as to giving security, or time or mode of trial, or otherwise, as is deemed just.

4:46-5. Affidavits

(a) Specific Facts Required of Adverse Party unless Affidavits are Unavailable. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of his pleading, but his response by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment, if appropriate, shall be entered against him, unless it appears from the affidavits submitted by him that he cannot, for reasons therein stated, present by affidavit facts essential to justify his opposition, in which case the court may deny the motion, may order a continuance to permit additional affidavits to be obtained, depositions to be taken or discovery to be had, or may make such other order as may be appropriate.

(b) Affidavits Made in Bad Faith. If the court is satisfied, at any time, that any of the affidavits submitted pursuant to this rule are presented in bad faith or solely for the purpose of delay, the court shall forthwith order the party employing them to pay to court shall forthwith order the party employing them to pay to the other party the amount of the reasonable expenses which the filing of the affidavits caused him to incur, including reasonable attorney's fees, and any offending party or attorney may be adjudged guilty of contempt.

IN THE

Supreme Court of the United States

OCTOBER TERM 1977

No. 76-1412

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell, Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Respondents.

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Richard McDonough, Commissioner of Insurance of the State of New Jersey, and James R. Cowan, M.D., Commissioner of Health of the State of New Jersey,

Respondents.

Appendix to Petition for Writ of Certiorari to the Supreme Court of the State of New Jersey

N.J. Appellate Printing Co., Inc., South Plainfield, New Jersey (201) 753-0200

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SUPERIOR COURT OF NEW JERSEY

CHANCERY DIVISION

HUDSON COUNTY

DOCKET NO. C-2684-71

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Plaintiffs,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, the Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, the Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Defendants.

COMPLAINT
(Filed December 4, 1972)

Plaintiffs, by way of Second Amended and Supplemental Complaint say:

Plaintiffs, John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO (TRUSTEES) bring this action individually and as a Class Action on behalf of all other Trustees of Welfare Funds of Labor Unions in the State of New Jersey similarly situated against the defendant hospitals to recover damages for violation of plaintiffs' rights under the Constitution and Laws of the United States of America and under the Constitution and Laws of the State of New Jersey, and to enjoin defendants from the continuing and further violation of those rights. Plaintiff, Howard Marks brings this action individually and as a Class Action on behalf of all members of Labor Unions similarly situated who are eligible to receive benefits under a Union Welfare Plan in effect in the State of New Jersey against the defendant hospitals to recover damages for violation of plaintiffs' rights under the Constitution and Laws of the United States of America and under the Constitution and Laws of the State of New Jersey, and to enjoin defendants from continuing any further violations of those rights.

CLASS ALLEGATIONS

Plaintiff Trustees are entrusted with the protection of the rights, privileges and benefits of members of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO who are eligible to receive benefits from the Welfare Fund of Local 464, pursuant to the terms of

the Welfare Plan. The members of the Class represented by Plaintiff Trustees are all Trustees of Welfare Funds of Labor Unions in the State of New Jersey who are charged by defendant hospital rates in excess of the rates charged to Blue Cross - Blue Shield Plan of New Jersey by the defendant hospitals for the same or similar services.

Plaintiff Marks is a member of Local Union 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO who is eligible for benefits from the Welfare Fund of Local 464 pursuant to the terms of the Welfare Plan. The members of the Class represented by plaintiff Marks are all those members of Labor Unions similarly situated who are eligible to receive benefits from a Union Welfare Fund for medical services, treatment or facilities provided by defendant hospitals in the State of New Jersey.

The class represented by Plaintiff Trustees and plaintiff Marks is so numerous that joinder of all members is impractical.

There are questions of law and fact common to the Class. The claims of plaintiff Trustees and plaintiff Marks are typical of the claims of the Class.

Plaintiff Trustees and plaintiff Marks will fairly and adequately protect the interest of the Class.

The defendant hospitals have acted on ground generally applicable to the Class and injunctive relief with respect to the Class is appropriate.

The question of law and fact common to the members of the class predominate over any questions affecting only individual members and a Class Action is superior to other available methods for the fair adjudication of the controversy between the parties herein.

PLAINTIFFS

1. Plaintiffs, John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, are Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO. The principal office of the Welfare Fund is maintained at 67 Sanford Street, in the City of East Orange, County of Essex and State of New Jersey. Plaintiff, Howard Marks, is a member in good standing of Local 464 and resides at 133 Avenue B, in the City of Bayonne, County of Hudson and State of New Jersey.

DEFENDANTS

2. Defendant, Bayonne Hospital, maintains its principal office at East 29th Street, in the City of Bayonne, County of Hudson and State of New Jersey.

3. Defendant, Beth Israel Hospital maintains its principal office at 70 Parker Avenue, in the City of Passaic, County of Passaic and State of New Jersey.

3a. Defendant, Bergen Pines County Hospital maintains its principal office at 1 Ridgewood Avenue, in the Borough of Paramus, County of Bergen and State of New Jersey.

4. Defendant, Clara Maass Memorial Hospital, maintains its principal office at Franklin Avenue, in the Town of Belleville, County of Essex and State of New Jersey.

5. Defendant, Englewood Hospital Association, maintains its principal office at 350 Engle Street, in the City of Englewood, County of Bergen and State of New Jersey.

6. Defendant, Greater Paterson General Hospital, maintains its principal office at 528 Market Street, in the City of Paterson, County of Passaic and State of New Jersey.

7. Defendant, Hackensack Hospital, maintains its principal office at 22 Hospital Place, in the City of Hackensack, County of Bergen and State of New Jersey.

8. Defendant, Irvington General Hospital, maintains its principal office at 832 Chancellor Avenue, in the Town of Irvington, County of Essex and State of New Jersey.

9. Defendant, Holy Name Hospital, maintains its principal office at 718 Teaneck Road, in the Township of Teaneck, County of Bergen and State of New Jersey.

10. Defendant, The Hospital Center at Orange, maintains its principal office at 188 South Essex Avenue, in the City of Orange, County of Essex and State of New Jersey.

11. Defendant, Morristown Memorial Hospital, maintains its principal office at 100 Madison Avenue, in the Town of Morristown, County of Morris and State of New Jersey.

12. Defendant, Monmouth Medical Center, maintains its principal office at 200 2nd Avenue, in the City of Long Branch, County of Monmouth and State of New Jersey.

13. Defendant, Mountainside Hospital, maintains its principal office at Bay & Highland Avenue, in the Town of Montclair, County of Essex and State of New Jersey.

14. Defendant, Newark Beth Israel Medical Center, maintains its principal office at 201 Lyons Avenue, in the City of Newark, County of Essex and State of New Jersey.

15. Defendant, Riverdell Hospital, maintains its principal office at 576 Kinderkamack Road, in the Borough of Oradell, County of Bergen and State of New Jersey.

16. Defendant, Saddle Brook Hospital, maintains its principal office at 300 Market Street, in the Township of Saddle Brook, County of Bergen and State of New Jersey.

17. Defendant, Saint Barnabas Medical Center, maintains its principal office at Old Short Hills Road, in the Township of Livingston, County of Essex and State of New Jersey.

18. Defendant, St. Michael's Medical Center, maintains its principal office at 306 High Street, in the City of Newark, County of Essex and State of New Jersey.

19. Defendant, South Amboy Memorial Hospital, maintains its principal office at 540 Bordentown Avenue, in the City of South Amboy, County of Middlesex and State of New Jersey.

20. Defendant, St. Joseph's Hospital, maintains its principal office at 703 Main Street, in the City of Paterson, County of Passaic and State of New Jersey.

21. Defendant, St. Mary's Hospital, maintains its office at Fourth Street and Willow Avenue, in the City of Hoboken, County of Hudson and State of New Jersey.

22. Defendant, St. Mary's Hospital, maintains its principal office at 211 Pennington Avenue in the City of Passaic, County of Passaic and State of New Jersey.

23. Defendant, Richard McDonough is the Commissioner of Insurance of the State of New Jersey and is empowered and charged by the Legislature of the State of New Jersey with the responsibility as set out in Titles 17 and 26 of the New Jersey statutes to supervise, regulate and, in consultation with the Commissioner of Health, approve the rate of payment to be made by hospital service corporations to health care facilities.

24. Defendant, James R. Cowan, M.D. is the Commissioner of Health of the State of New Jersey and is empowered and charged by the Legislautre of the State of

New Jersey with the responsibility as set out in Titles 17 and 26 of the New Jersey statutes to supervise, regulate and, in consultation with the Commissioner of Insurance, approve the rates of payment to be made by hospital service corporations to health care facilities.

25. The defendant, Blue Cross - Blue Shield Plan of New Jersey is a corporation of the State of New Jersey under the Laws of the State of New Jersey maintaining its principal office at 33 Washington Street, in the City of Newark, County of Essex, State of New Jersey and is engaged in the business of providing health insurance plans in the State of New Jersey.

FIRST COUNT

26. On April 9th, 1971, Howard Marks, a member of Local 464 and an eligible beneficiary of the Welfare Plan of Local 464, was admitted as a patient to the Bayonne Hospital for treatment and medical services. Trustees of the Fund were required to pay to the defendant hospital the sum of $65.00 per day for a semi-private room for Mr. Marks. For these services and for other services the Plaintiff Trustees and the Fund were required to pay an amount of money in excess of the amount required to be paid by the Blue Cross-Blue Shield Health Services Plan, on behalf of persons who are eligible for benefits under the Blue Cross - Blue Shield Plan for the same or similar services, treatment, and facilities.

27. There is no factual distinction between the health services, treatment or facilities provided to the Union beneficiaries of the Fund and the similar services, treatment and facilities provided to persons covered under the Blue Cross-Blue Shield Plan, nor is there any substantive or rational basis for the defendant hospital to require payments from

the Trustees of the Welfare Fund in amounts in excess of the payments required to be paid to the hospitals by the Blue Cross-Blue Shield Plan for the same or similar services.

28. Each of the defendant hospitals have engaged in acts of discrimination against the plaintiffs, and all members of plaintiffs' class, to wit, they have demanded and received sums of money at a rate in excess of the rate demanded and received from the Blue Cross-Blue Shield Plan of New Jersey to provide the same or similar medical service, treatment and facilities.

29. Defendant hospitals by virtue of their financial support and structure, tax status and benefits, functions, associations and affiliation with local state and federal units of government, and by virtue of their licensing, certification, examination and authorization by the State of New Jersey and the United States of America to engage in the offering of hospital and medical services and the receipt of compensation therefrom, have assumed a governmental nature and are engaged in governmental activities.

30. The above described acts of discrimination by defendant hospitals against plaintiffs, and all members of plaintiffs class, constitute illegal discriminatory state action.

31. Said acts of discrimination by defendant hospitals constitute a deprivation, without due process of the right to protect property contrary to the provisions of Article I, paragraph I of the Constitution of New Jersey.

32. As a result of the above described discriminatory acts, plaintiffs have suffered injury and will continue to suffer injury and unless said acts are enjoined, plaintiffs will suffer irreparable injuries.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Directing the defendant hospitals to immediately offer to make available to plaintiffs and all members of plaintiffs' class, services, treatment and facilities at a rate schedule of payments equal to and as favorable as the rate schedule for payments offered and made available to Blue Cross-Blue Shield Plan of New Jersey.

D) Defendants, by way of damages, pay into the Court a sum of money, to be held in escrow for the benefit of all injured persons, equal to any and all sums of money demanded and received at any time by the defendant hospitals from any persons in excess of the amount of money they would have been required to pay under the rate schedule made available to Blue Cross-Blue Shield Plan of New Jersey.

E) Directing that the defendant hospitals pay to the plaintiffs a rea nable counsel fee, costs of suit plus interest.

SECOND COUNT

33. Plaintiffs repeat, reiterate and make a part herein of all the allegations set out in the previous count of this Complaint.

34. Plaintiff trustees, and all members of the class of trustees, are responsible for the administration of welfare funds of labor unions pursuant to welfare plans and are obliged to protect the rights, privileges and benefits of members of labor unions who are eligible for fund benefits. Plaintiff Marks and all members of the class of beneficiaries of welfare funds, are members of labor unions in New Jersey who are eligible for benefits from a labor union welfare plan.

35. The terms, assets and benefits of the above described welfare plans are the subject of collective bargaining by the labor unions and employers.

36. Defendant hospitals have engaged in acts of discrimination by demanding and receiving from plaintiffs, and members of plaintiffs class sums of money in excess of sums of money demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the furnishing of medical services, treatment and facilities.

37. By the above described acts of discrimination, defendant hospitals have caused the assets of the welfare funds, of which plaintiffs are trustees and beneficiaries, to become depleted and diminish in value.

38. The above described acts of discrimination by defendant hospitals constitute an infringement and deprivation of the right of plaintiffs to organize and bargain collectively, contrary to Article I paragraph XIX of the Constitution of New Jersey.

39. As a result of said infringement, impairment and deprivation, plaintiffs have suffered injury and unless and until said wrongful acts are enjoined, plaintiffs will continue to suffer irreparable injuries.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Directing the defendant hospital to immediately offer to make available to plaintiffs and all members of plaintiffs' elass, services, treatment and facilities at a rate schedule of payments equal to and as favorable as the rate schedule for payments offered and made available to the Blue Cross-Blue Shield Plan of New Jersey or any other Health or Welfare Plan.

D) Enjoining the defendant hospitals from any acts which constitute infringements, impairment and deprivation of the plaintiffs right to organize and bargain collectively.

E) Directing that the defendant hospital pay to the plaintiffs a reasonable counsel fee, costs of suit plus interest.

THIRD COUNT

40. Plaintiffs repeat, reiterate and make a part herein all the allegations previously set out in the Complaint.

41. Hospital services and services incidental thereto (medical or otherwise) are fundamental needs and human

rights protected by the due process clause of the 14th Amendment to the Constitution of the United States and require the equal protection of the laws in accordance with that Amendment.

42. The defendant hospitals, acting under color of law, have engaged in activities which constitute a denial to the plaintiffs and all members of plaintiffs' class the equal protection of the laws in that the defendants have dealt with persons similarly situated in an arbitrary and discriminatory manner.

43. More particularly describing the activities referred to in paragraph 42 the defendant hospitals, in their governmental nature and by way of performing governmental functions have applied an unequal and discriminatory rate schedule applied to a similarly situated persons, namely, Blue Cross-Blue Shield Plan of New Jersey for the same or similar services, treatment or facilities.

44. The above described acts of the defendant hospitals have resulted in injury to the plaintiffs and constitute State denial to persons within its jurisdiction of the equal protection of the laws in contravention of the provisions of Section 1 of Fourteenth Amendment of the United States Constitution.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Directing the defendant hospitals to immediately offer to make available to plaintiffs and all members of plaintiffs' class, services, treatment and facilities at a rate schedule for payments offered and made available to the Blue Cross-Blue Shield Plan of New Jersey or any other Health or Welfare Plan.

D) Directing that the defendant hospital pay to the plaintiffs a reasonable counsel fee, costs of suit plus interest.

FOURTH COUNT

45. Plaintiffs repeat, reiterate and make a part herein all of the allegations previously set forth in this Complaint.

46. In accordance with N.J.S. 17:48-7 the rates of payment by a hospital service corporation, including the Blue Cross-Blue Shield Plan of New Jersey made pursuant to a written contract to a hospital or institution for service contracted thereunder are required to be approved as to reasonableness by the Commissioner of Insurance, defendant Richard McDonough.

47. Defendant Richard McDonough, in the exercise of the above described power to approve as to reasonableness, has acted in a discriminatory and unfair manner and thereby has created an invidious classification in relationship to the plaintiffs in that such classfication is

irrational, discriminatory and denies to the plaintiffs and all members of plans of hospital service corporations, except the Blue Cross-Blue Shield Plan of New Jersey, the equal protection of the laws in contravention of the provisions of Section I of the Fourteenth Amendment of the United States Constitution.

48. More particularly specifying the denial of equal protection of the laws by the defendant Commissioner, the Commissioner has approved the plan and imposition upon the plaintiffs by the defendant Blue Cross-Blue Shield Plan of New Jersey, the equal protection of the laws in contravention of the provisions of Section I of the Fourteenth Amendment of the United States Constitution.

48. More particularly specifying the denial of equal protection of the laws by the defendant Commissioner, the Commissioner has approved the plan and imposition upon the plaintiffs by the defendant Blue Cross-Blue Shield Plan of New Jersey Inc. and the defendant hospitals of an exorbitant and excessive rate for the same or similar services offered to the Blue Cross-Blue Shield Plan Inc. of New Jersey for a lower rate. The rates of payment approved by the Commissioner are based upon a calculation which imposes penalty upon the plaintiff and a discount to the Blue Cross-Blue Shield Plan of New Jersey Inc. Said discount is directly dependent upon the discriminatory rates imposed upon the plaintiffs and approved by the Commissioner.

49. The above described actions of the defendant Richard McDonough were done in his capacity as a representative of the State of New Jersey and in pursuance of a specific regulatory function as mandated by the above designated State Statute and thereby such actions constitute illegal state action, and have resulted in injury

and loss of property and valuable assets to the plaintiffs and all members of plaintiffs' class and constitute a deprivation by the State of New Jersey of the property of plaintiffs and all members of plaintiffs' class without due process of law, in contravention of the provisions of Section I of the Fourteenth Amendment of the Constitution of the United States.

WHEREFORE, plaintiffs demand Judgment against the defendants:

A) Enjoining and restraining the defendants from demanding and receiving from the plaintiffs or any members of plaintiffs' class, payments for medical services or treatment at a rate in excess of the rate for payments demanded and received from the Blue Cross-Blue Shield Plan of New Jersey for the same or similar medical services or treatment.

B) That the defendants, jointly and severally pay to the plaintiffs by way of damages a sum of money equal to the amount of payments demanded and received from the plaintiffs in excess of the amount they would have been required to pay to defendants under the rate schedule made available to the Blue Cross-Blue Shield Plan of New Jersey.

C) Defendants, by way of damages, pay into the Court a sum of money, to be held in escrow for the benefit of all injured persons, equal to any and all sums of money demanded and received at any time by the defendant hospitals from any persons in excess of the amount of money they would have been required to pay under the rate schedule made available to Blue Cross-Blue Shield Plan of New Jersey.

D) Directing the defendant hospitals to immediately offer to make available to plaintiffs and all members of

plaintiffs' class, services, treatment and facilities at a rate schedule for payments offered and made available to the Blue Cross-Blue Shield Plan of New Jersey or any other Health or Welfare Plan.

E) Directing that the defendant hospitals pay to the plaintiffs a reasonable counsel fee, costs of suit plus interest.

FIFTH COUNT

50. Plaintiffs repeat, reiterate and make a part hereof all of the allegations previously set forth in this Complaint.

51. Pursuant to N.J.R.S. 17:48-7 and 26:2H-18 the rates of payment by a hospital service corporation including the Blue Cross-Blue Shield Plan of New Jersey made pursuant to a written contract with a health care facility, are required to be approved by the Commissioner of Health in consultation with the Commissioner of Insurance is required to certify the cost of providing health care services as reported by each health care facility, and the Commissioner of Insurance with the approval of the Commissioner of Health is empowered to evaluate the reasonableness of proposed contractual payments by hospital service corporations to meet those costs. The law requires the Commissioners in making their respective determinations to take into account the total operating costs of the health care facility.

52. Defendants Richard McDonough and James R. Cowan, M.D. in the exercise of their statutory authority have acted in a discriminatory, unfair and illegal manner in failing to take into account, for the purpose of establishing the rates of payment to be made by the Blue Cross-Blue Shield Plan of New Jersey, all of the costs of the respective health care facilities. They have thereby

created a classification which is irrational and discriminatory and which denies to plaintiffs and all members of plaintiffs' class the protection contemplated by the statute.

53. More particularly specifying the unlawful and discriminatory acts of defendant Commissioners, said Commissioners in approving the rates of payment to be made by the Blue Cross-Blue Shield Plan of New Jersey to defendant hospitals have failed to take into account some of the costs necessary to the operation of defendant hospitals, as a result of which said hospitals must and do charge plaintiffs and others similarly situated not just for the value of services rendered, but an additional sum to make up for the deficiency in the payment by Blue Cross-Blue Shield. The approval by the Commissioner of a discount for Blue Cross-Blue Shield results in a discriminatory rate and imposes a penalty upon plaintiffs in violation of the laws of the State of New Jersey as aforesaid.

54. As a result of the illegal acts of the Commissioners of Health and Insurance as herein set forth the assets of plaintiffs' Welfare Fund and the assets of the welfare funds of all members of plaintiffs' class have been diminished, depleted and impaired.

55. In the alternative, plaintiffs allege that if the acts of the Commissioners of Health and Insurance herein complained of are found to be permissible under Titles 17 and 26 of the Laws of the State of New Jersey, then such laws as construed and applied by the Commissioners are repugnant to the equal protection clause of the Fourteenth Amendment to the Constitution of the United States and contravene such clause to the extent to which they authorize unequal and unfair rates and charges to plaintiffs and to other members of plaintiffs' class.

WHEREFORE, plaintiffs demand Judgment:

A) Directing the Commissioner of Insurance and the Commissioner of Health to withdraw their approval of the present and discriminatory rate pattern and to require the establishment of contractual relations between defendant hospitals and the Blue Cross-Blue Shield Plan of New Jersey under which the latter will be required to pay at the same rate as is required of plaintiffs for similar services, treatment and facilities.

60. More particularly specifying the acts and conspiracy of defendants set out in paragraph 59 above, the defendant hospitals, with the approval, consent, and cooperation of the officers, employees and directors of the Blue Cross-Blue Shield Plan, have offered and made available to the Blue Cross-Blue Shield Plan, health services, facilities and treatment at a rate of payment less than the rate of payment offered and made available to the plaintiffs, and to members of plaintiffs' class, for the same or similar services. Said acts and conspiracy have been in furtherance of the monopolization and the attempt to monopolize the commerce and trade of providing group health services. More particularly specifying the said acts and conspiracy, the defendant, together with the officers, employees and directors of the Blue Cross-Blue Shield Plan, have attempted to and have depleted the assets of plaintiff trustees welfare fund and thereby are acting toward the purpose of eliminating plaintiff trustees, and members of plaintiff trustees' class and other persons in the business of group health insurance from the commerce and trade of providing group health services and insurance.

61. The acts and conspiracy of defendant hospitals and the officers, employees and directors of Blue Cross-Blue Shield Plan, have been in furtherance of a plan and a

scheme to eliminate competition, and more particularly, the defendant hospitals by practicing discrimination towards the plaintiffs and all members of plaintiffs' class in charging them exorbitant and higher rates, have thereby made it possible for them to provide a discount rate schedule to the Blue Cross-Blue Shield Plan.

62. The acts and conspiracy of defendant hospitals and the officers, employees and directors of Blue Cross have been in furtherance of a common plan and a mutual scheme, in violation of the New Jersey Anti Trust Act (N.J.S.A. 56:9-1 et seq), to charge the plaintiff and members of the class of unions similarly situated more than subscriber's of defendants' Blue Cross for the same equipment, facilities and services, thus depriving plaintiff and members of their class of their property by reason of such acts, conspiracy, common plan, mutual scheme and monopolization in violation of the provisions of the New Jersey Anti Trust Law.

63. As a result of the above described acts and conspiracy of defendants, the assets of plaintiffs' welfare fund and the assets of all of plaintiffs' class have been diminished, depleted and impaired. Until and unless defendants are permanently enjoined and restrained from continuing such conspiracy, acts and practices, the plaintiffs will suffer further losses and irreparable damage.

64. The above described acts, conspiracy, common plan, mutual scheme, restraint of trade and monopolization are in violation of the New Jersey Anti Trust Act (N.J.S.A. 56:9-1 et seq.).

WHEREFORE, plaintiffs demand:

A) Judgment against defendants in favor of plaintiffs for three times the amount of damages determined to have been sustained by plaintiffs together with the cost of suit, including a reasonable attorney's fee;

B) That the defendants, their present and future officers, directors, employees, agents, successors and assigns, be preliminarily and perpetually enjoined, restrained and prohibited from entering into, adhering to, renewing, maintaining or furthering, directly or indirectly, any like or similar combination and conspiracy to restrain and monopolize trade and commerce of offering group health services in the State of New Jersey.

KRIEGER & CHODASH
Attorneys for plaintiffs

By: /s/ Harold Krieger
HAROLD KRIEGER
A Member of the Firm

JURY DEMAND

Plaintiffs hereby demand a jury of 12 persons as to all issues of plaintiffs' application to proceed in a summary manner is not granted.

KRIEGER & CHODASH
Attorneys for plaintiffs

By: /s/ Harold Krieger
HAROLD KRIEGER
A Member of the Firm

ANSWER FILED BY THE COMMISSIONERS OF HEALTH AND INSURANCE

Defendants, Commissioners of Insurance and Health of the State of New Jersey, answering the Complaint of plaintiffs says:

AS TO THE FIRST COUNT

1. They are without knowledge or information sufficient to form a belief as to the truths of the allegations in paragraphs 26, 27, 28, 29, 30, 31 and 32 and leaves plaintiffs to their proofs.

AS TO THE SECOND COUNT

1. They repeat their answers to the First Count of the Complaint in Answer to paragraph 33 and incorporate the same herein by reference as if they were fully set forth at length.

2. They are without knowledge or information sufficient to form a belief as to the truths of the allegations in paragraphs 34, 35, 36, 37, 38, and 39 and leaves plaintiffs to their proofs.

AS TO THE THIRD COUNT

1. They repeat their answers to the First and Second Counts of the Complaint in answer to paragraph 40 and incorporates the same herein by reference as if they were fully set forth at length.

2. They are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraphs 41, 42, 43, and 44 and leaves plaintiffs to their proofs.

AS TO THE FOURTH COUNT

1. They repeat their answers to the First, Second and Third Counts of the Complaint in answer to paragraph 45

and incorporates the same herein by reference as if they were fully set forth at length.

2. They admit the allegations in paragraph 46.

3. They deny the allegations in paragraphs 47, 48 and 49.

AS TO THE FIFTH COUNT

1. They repeat their answer to the First, Second, Third and Fourth Counts of the Complaint in answer to paragraph 50 and incorporates the same herein by reference as if they were fully set forth at length.

2. They admit the allegations in paragraph 51.

3. They deny the allegations in paragraphs 52, 53 and 55.

4. They are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph

This action is not maintainable because the Complaint fails to state a claim upon which relief can be granted.

RESERVATION OF RIGHT TO MOVE TO DISMISS COMPLAINT

This defendant reserves the right, at or before the trial of this action, to move to dismiss the Complaint for the reason to set forth in his separate defense.

GEORGE F. KUGLER, JR.
Attorney General of New Jersey
Attorney for Defendants,
New Jersey Commissioners of
Insurance and Health

By: /s/ Steven R. Bolson
STEVEN R. BOLSON
Deputy Attorney General

MOTION BY BLUE CROSS FOR SUMMARY JUDGMENT

TO: KRIEGER & CHODASH, ESQS.
Attorney for Plaintiffs
921 Bergen Avenue
Jersey City, New Jersey

SIRS:

PLEASE TAKE NOTICE that on Friday, September 29, 1972, at 9:00 o'clock in the forenoon, or as soon thereafter as counsel may be heard, the undersigned, attorneys for the defendant Hospital Service Plan of New Jersey, will move before the Superior Court, Chancery Division, Hudson County, at the Court House, Jersey City, New Jersey, for Summary Judgment in its favor pursuant to R. 4:46 of the Rules of New Jersey on the ground that there exists no genuine issue as to any material fact and that defendant Hospital Service Plan of New Jersey is entitled to a Judgment in its favor as a matter of law.

PLEASE FURTHER NOTICE that in support of the within motion defendant Hospital Service Plan of New Jersey will rely upon the brief and affidavit submitted by the defendant hospitals in their application for an Order dismissing the Amended and Supplemental Complaint.

PITNEY, HARDIN & KIPP

By: /s/ Clyde A. Szuch
CLYDE A. SZUCH
A Member of the Firm

STATEMENTS

The originals of the within Motion for Summary Judgment and all supporting papers required to be filed have been sent for filing to the Clerk of the Superior Court.

/s/ Ronald E. Wiss
RONALD E. WISS

A clear copy of the within Motion for Summary Judgment together with originals or clear copies, as appropriate, of all supporting papers have been sent for filing to Judge A. Alfred Fink, Court House Administration Building, Jersey City, New Jersey.

/s/ Ronald E. Wiss
RONALD E. WISS

CERTIFICATE OF SERVICE

I hereby certify that on this date copies of the Motion for Summary Judgment were served upon all other counsel of record in this matter by mailing the same, first class mail, postage prepaid, at Newark, New Jersey, addressed to their respective offices:

/s/ Ronald E. Wiss
RONALD E. WISS

DATED: September 22, 1972

HOSPITAL'S MOTION TO DISMISS COMPLAINT

TO: KRIEGER & CHODASH, ESQS.
Attorneys for Plaintiffs
921 Bergen Avenue
Jersey City, New Jersey

SIRS:

PLEASE TAKE NOTICE that on Friday, September 29, 1972, at 9:00 o'clock in the forenoon, or as soon thereafter as counsel may be heard, the undersigned, attorneys for the defendant hospitals listed below, will apply to the Superior Court, Chancery Division, Hudson County, at the Court House, Jersey City, New Jersey, for an Order dismissing the FIRST, SECOND and THIRD Counts of the Amended and Supplemental Complaint its entirety as said defendant hospitals for the reason that said Amended and Supplemental Complaint fails to state a claim upon which relief can be granted against defendant hospitals.

In support of this motion, defendants will rely upon the brief and affidavit submitted herewith.

DATED: September 12, 1972

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By: /s/ Herbert S. Alterman

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By: /s/

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By: /s/

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By: /s/ Bate

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By: /s/

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By: /s/ Harold G. Smith

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Saddle Brook Hospital

By: /s/ John F. McCann

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and St. Mary's Hospital of
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By: /s/

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201-546-5400
Attorneys for Defendant
St. Mary's Hospital of
Passaic

By: /s/ Frank A. Ferrante

AFFIDAVIT OF LESTER M. BORNSTEIN
(Annexed to Foregoing Motion)

STATE OF NEW JERSEY:
SS:
COUNTY OF ESSEX :

LESTER M. BORNSTEIN, of full age being duly sworn upon his oath deposes and says:

1. I reside at 6 Ahern Way, West Orange, New Jersey.

2. I am Executive Director of Newark Beth Israel Medical Center, one of the defendants in Borland et al v. Bayonne Hospital et al and have served as Executive Director of Newark Beth Israel Medical Center since 1968. In my position as Executive Director I am fully familiar with the procedures followed by hospitals which have contracted with New Jersey Blue Cross with respect to the setting of Blue Cross reimbursement rates.

3. In October or November of each year the contracting hospitals prepare and submit proposed operating budgets for the coming calendar year to the Budget and Advisory Committee appointed by the Commissioner of Insurance. The Committee is assisted in its review by the Budget Reviewing Staff, a division of the Hospital Research and Educational Trust of New Jersey.

4. The budgets must be submitted on forms provided by the Commissioner of Insurance. These forms exclude certain items of non-reimbursable costs.

5. On the basis of the budgets submitted the Committee recommends to the Commissioner of Insurance for his approval a tentative per diem reimbursement rate for the operating year for admissions to each hospital. The rate, when approved by the Commissioners of Insurance and

Health, becomes the rate used by New Jersey Blue Cross in its reimbursement for services rendered to subscribers. Neither Blue Cross nor the contracting hospitals has the right to alter the rate established by the Commissioners.

6. At the end of each year the hospitals' results of operations are audited by accountants for New Jersey Blue Cross. In the event that the interim rate resulted in an overpayment based on actual costs incurred by a contracting hospital, an adjustment must be made in favor of Blue Cross. Prior to 1968 a similar adjustment was automatically made in favor of the contracting hospital in the event that the results of the audit showed that the costs exceeded the established interim rate. Since at least 1968, however, the interim rate established by the Commissioners of Health and Insurance has in effect become a ceiling rate with the result that costs in excess of the interim rate may be recovered only if approved by the Commissioners following an appeal by the affected hospital.

/s/ Lester M. Bornstein
LESTER M. BORNSTEIN

NOTARIZED

CERTIFICATION

I HEREBY CERTIFY that the original of the within Notice of Motion to Dismiss Complaint, returnable September 29, 1972, has been filed with the Clerk of the Superior Court of New Jersey, State House Annex, Trenton, New Jersey, and that a clear copy thereof has been filed with The Honorable Alfred A. Fink, at the Court House, Jersey City, New Jersey.

/s/ Dickinson R. Debevoise
DICKINSON R. DEBEVOISE

DATED: September 12, 1972.

CERTIFICATE OF SERVICE

IT IS HEREBY CERTIFIED that a copy of the within Notice of Motion to Dismiss Complaint and Brief in support thereof have been served upon the following at the addresses set forth below by certified mail, return receipt requested, this 12th day of September, 1972:

Krieger & Chodash, Esqs.
921 Bergen Avenue
Jersey City, New Jersey

Hon. George F. Kugler, Jr.
Attorney General of New Jersey
State House Annex
Trenton, New Jersey

Hon. Richard McDonough
Commissioner of Insurance
State House Annex
Trenton, New Jersey

Hon. James R. Cowan
Commissioner of Health
State House Annex
Trenton, New Jersey

Pitney, Hardin & Kipp, Esqs.
Attorneys for Blue Cross
570 Broad Street
Newark, New Jersey

/s/ Dickinson R. Debevoise
DICKINSON R. DEBEVOISE

DECISION IN BORLAND, et al v. BAYONNE HOSPITAL, et al GRANTING BOTH MOTIONS FOR SUMMARY JUDGMENT IN FAVOR OF THE DEFENDANTS

Argued January 5, 1973. Decided

Messrs. Krieger & Chodash, attorneys for plaintiffs, by Mr. Harold Krieger,

Messrs. Smith, Stratton, Wise & Heher, attorneys for defendant, Bayonne Hospital, by Mr. John R. Heher,

Messrs. Lebson & Prigoff, attorneys for defendant, Englewood Hospital Association, by Mr. John F. Fegelein,

Messrs. Morrison & Griggs, attorneys for defendant, Greater Paterson General Hospital, by Mr. Donald W. de Cordova,

Messrs. Winne & Banta, attorneys for defendant, Hackensack Hospital Association, by Mr. Peter G. Banta,

Messrs. Kein, Pollatschek & Iacopino, attorneys for defendant, Irvington General Hospital, by Mr. Vincent J. Iacopino,

Messrs. Breslin & Breslin, atorneys for the defendant, Holy Name Hospital, by Mr. Charles Rodgers,

Messrs. Riker, Danzig, Scherer & Brown, attorneys for defendants, The Hospital Center at Orange and Saint Barnabas Medical Center, by Mr. Dickinson R. Debevoise,

Messrs. Schenck, Price, Smith & King, attorneys for defendant, Morristown Memorial Hospital, by Mr. Clifford W. Starrett,

Messrs. Booth, Bate, Hagoort, Keith & Harris, attorneys for defendant, The Mountainside Hospital, by Mr. David S. Bate,

Messrs. Lowenstein, Sandler, Brochin, Kohl & Fisher, attorneys for defendant, Newark Beth Israel Medical Center, by Mr. Bruce D. Shoulson,

Messrs. Clapp & Eisenberg, attorneys for defendant, Riverdell Hospital, by Mr. Stuart L. Pachman,

Messrs. McCann & McCann, attorneys for defendant, Saddle Brook Hospital, by Mr. Edmund V. McCann,

Messrs. Milton, Keane & Brady, attorneys for defendants, St. Michael's Medical Center and St. Mary's Hospital of Hoboken, by Mr. William F. Tuohey,

Messrs. Johnson, Johnson & Murphy, attorneys for defendant, St. Joseph's Hospital, by Mr. William F. Johnson, Jr.,

Messrs. Mandak, Roth & Ferrante, attorneys for defendant, St. Mary's Hospital of Passaic, by Mr. Frank A. Ferrante,

Mr. George F. Kugler, Jr., Attorney General of New Jersey, attorney for defendants, Commissioner of Insurance and Commissioner of Health, by Mr. Mark L. First, Deputy Attorney General,

Messrs. Pitney, Hardin & Kipp, attorneys for defendant, Hospital Service Plan of New Jersey, by Mr. Clyde A. Szuch,

Mr. Herbert Alterman, attorney for defendant, Beth Israel Hospital,

Mr. Michael J. Ferrara, attorney for defendant, Bergen Pines County Hospital,

Messrs. Smith, Kramer & Morrison, attorneys for defendant, Clara Maas Memorial Hospital,

Messrs. Giordano, Giordano & Halleran, attorneys for defendant, Monmouth Medical Center,

Messrs. Wilentz, Goldman & Spitzer, attorneys for defendant, South Amboy Memorial Hospital.

FINK, J.S.C.

Plaintiffs, Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters and Food Store Employees Union, AFL-CIO (hereinafter "Union"), and Howard Marks, a union member and eligible beneficiary of the union welfare plan, have instituted the within action against twenty-two New Jersey hospitals, the Hospital Service Plan of New Jersey (herein impleaded as "The Blue Cross-Blue Shield Plan of New Jersey"), the New Jersey Commissioner of Insurance and the New Jersey Commissioner of Health.

The suit is filed as a class action on behalf of labor union welfare funds in the State providing medical service benefits not funded through Blue Cross and members of labor unions providing such plans. Plaintiffs seek injunctive relief and damages for alleged discrimination by defendant hospitals in charging plaintiffs higher rates for hospital services than are charged to Blue Cross subscribers for identical service.

The complaint asserts that the differential in rates is illegal and improper in that:

1. It deprives plaintiffs of due process under Article I, Paragraph 1 of the State Constitution;

2. It deprives plaintiffs of equal protection of the laws under the United States and State Constitutions;

3. It constitutes an infringement of the right to bargain collectively contrary to Article I, Paragraph XIX of the State Constitution;

4. It is the end result of a conspiracy between the hospitals and Blue Cross in furtherance of a common plan and mutual scheme in violation of the New Jersey Anti-Trust Act (*N.J.S.A.* 56:9-1 *et seq.*)

Defendant hospitals moved to dismiss the complaint as it applies to them on the ground that the complaint fails to state a cause of action against them. This motion, under *R.* 4:6-2, will be treated as a motion for summary judgment.

Defendant, Hospital Service Plan of New Jersey (hereinafter "Blue Cross") moved for summary judgment on the ground that there exists no genuine issue as to any material fact and that Blue Cross is entitled to a judgment in its favor as a matter of law.

The Commissioner of Insurance and the Commissioner of Health have filed an answer but do not join in these motions.

The right to proceed with this litigation as a class action under *R.* 4:32-1 has not yet been established. The parties have stipulated that the proceedings necessary to establish this litigation as a class action should be held in abeyance until the determination of the pending motions.

The threshold question is whether the matter is ripe for summary judgment as between the plaintiffs, the hospitals and the Hospital Plan of New Jersey.

For the reasons that follow, it is my judgment that the issues involved are legal in nature only.

All of the parties admit that there is such a differential, that is, the plaintiffs, commercial insurance companies, individuals, labor unions and all others, pay for hospital services at higher rates than are prescribed by the Commissioner of Insurance and the Commissioner of Health for reimbursement for services rendered Blue Cross subscribers. At this point, it must be noted that Federal Agencies under the medicare program also pay less by reason of applicable statutory law. *N.J.S.A.* 26:2H-18(b); 42 *U.S.C.A.* Sec. 1395f(b); 20 *CFR*, Sec. 405, 401(a).

Plaintiffs assert that there are fact issues that preclude disposition of the case as to the hospitals and Blue Cross on a summary judgment basis. In their brief, they state:

> "The unknown factual questions which necessitate and warrant discovery stem from the first negotiations between N.J. Hospitals and Blue Cross, whereby a formula is determined and agreed upon between the parties, which is then used to calculate the per diem rate to be charged Blue Cross subscribers *after approval by the Commissioners of Insurance and Health*. The secrecy of these negotiations, and the defendants refusal to stipulate as to these matters has created a factual question which must be exposed by discovery. This factual question is: what specific cost and expense items are excluded or included from the total costs (as required by *NJRS*. 26:2H-4) in arriving at the formula which is used as basis for calculation of the per diem rate charged Blue Cross subscribers, and as a result thereof, fixes the discriminatory rate charged non-Blue Cross subscribers."

Plaintiffs' contention overlooks the fact, however, that neither Blue Cross nor the hospitals control how much Blue Cross reimburses the hospitals for services rendered to Blue Cross subscribers. That function is vested in the Commissioner of Insurance of the State of New Jersey with the approval of the Commissioner of Health of the State of New Jersey by virtue of the Health Care Facilities Planning Act, *N.J.S.A.* 26:2H-18(d). On the other hand, the power and duty to determine charges made to the general public remain vested in the governing bodies of the defendant hospitals. The rate making process under the above Act requires the rate of payment by Blue Cross to participating hospitals to be approved annually. The actual procedure is that in October or November of the preceding year each hospital prepares and submits its proposed operating budget for the coming calendar year to the Budget and Advisory Committee appointed by the Commissioner of Insurance. The Advisory Committee consists of three physicians, five hospital administrators, and four hospital trustees. The Committee is assisted in its review by the Budget Review Staff, a division of the Hospital Research and Educational Trust of New Jersey. The Health Care Facilities Planning Act requires the Commissioner of Health, in consultation with the Commissioner of Insurance, to determine and certify the costs of providing health care services based on reports prepared by the hospitals in accordance with a uniform system of cost accounting. (*N.J.S.A.* 26:2H-18(c)).

The Committee recommends to the Commissioner for his approval a tentative per diem reimbursement rate for the operating year for admissions to each hospital.

It is conceded by the hospitals and Blue Cross that in computing reimbursement rates by Blue Cross the

Commissioners of Insurance and Health omit from consideration some of the costs necessary to the operation of hospitals (e.g. the cost of providing indigent care). As a result the rates hospitals charge others, including plaintiffs, is computed to permit the hospitals to recapture their omitted costs. The difference in rates is said to approximate twenty per-cent.

Thus the alleged questions of fact are not questions of fact at all. The hospitals and Blue Cross concede that the reimbursement rate paid by Blue Cross for services rendered to subscribers is less than the rates paid by plaintiffs and others, and they also concede the method by which those different rates are established. Their response, however, is that they do not control the ultimate reimbursement rate paid by Blue Cross; that this is the sole function of the Commissioners of Insurance and Health, and that plaintiffs' complaints against them are misdirected.

In the face of the admission by the hospitals and Blue Cross that some items of cost are omitted by the Commissioners of Insurance and Health in calculating the reimbursement rate, I see no necessity for a plenary hearing to determine the precise item or items of cost that are omitted from consideration by the Commissioners of Insurance and Health. That may become necessary in the remaining part of the action against the Commissioners of Insurance and Health. *N.J.S.A.* 26:2H-18(d) provides that in establishing such rates the Commissioners shall take into consideration the total costs of the hospitals. In actual practice, the form on which each hospital must submit its budget is provided by the Commissioner of Health. Such forms exclude certain items of non-reimbursible costs based on policy decisions made by the Commissioners of Health and Insurance, and this generally accounts for the difference between the reimbursement rates paid by Blue Cross and the hospital established rates to non hospital service corporations. Whether such omissions are in violation of the provisions of *N.J.S.A.* 26:2H-18(d) is, however, not an issue as between plaintiffs and the hospitals and Blue Cross. In fact, it is an issue which the hospitals themselves, in their brief, have reserved the right to raise at an appropriate time and in an appropriate proceeding. Insofar as the present litigation is concerned, the omission of costs is an issue as between the plaintiffs and the Commissioners of Health and Insurance.

Based upon the assumption that under the Health Care Facilities Act, *N.J.S.A.* 26:2H-1 *et seq.*, reimbursement rates to Blue Cross for service to its subscribers may be at a rate which is less than that charged to others, the hospitals and Blue Cross take the position that that is constitutionally permissible. The plaintiffs take the position that this is constitutionally impermissible. It is that issue, among others, that will occupy the attention of this Court in this opinion.

As to the allegations levelled by plaintiffs at the hospitals and Blue Cross involving "secret negotiations," "mutual schemes" and "conspiracy" to fix the rates Blue Cross pays, they are just that, namely, bare allegations. There is not a single pleaded fact to support them. In my opinion they are spurious and warrant no consideration.

THE CONSTITUTIONAL ISSUES ARISING UNDER THE DUE PROCESS CLAUSE OF THE NEW JERSEY CONSTITUTION AND THE EQUAL PROTECTION CLAUSE OF THE FEDERAL CONSTITUTION.

Plaintiffs allege a violation of their rights to due process under Article I, Paragraph 1 of the New Jersey Constitution and to equal protection under Section 1 of the Fourteenth Amendment of the United States Constitution.

"While due process and equal protection guarantees are not coterminous in their spheres of protection, equality of right is fundamental in both. Each forbids class legislation arbitrarily discriminating against some and favoring others in like circumstances." *Washington National Insurance Company v. Board of Review*, 1 *N.J.* 545 (1949).

Discrimination and inequality of rights are plaintiffs' sole complaints. Since those complaints invoke the same principles involving due process under the State Constitution, and equal protection under the Federal Constitution, they will be discussed under one heading.

Specifically, plaintiffs allege that the hospitals and Blue Cross illegally discriminate against them in violation of their constitutional rights in that the hospitals charge Blue Cross less for services rendered its subscribers than is charged to plaintiffs for identical services rendered to its members.

In challenging the rates paid by Blue Cross, plaintiffs are in effect challenging the constitutionality of the Hospital Service Corporation Act.

Not every inequality offends the constitutional provision of due process and equal protection. *Lindsley v. Natural Carbonic Gas Co.*, 220 *U.S.* 61, 78-79 (1911); *Dandridge v. Williams*, 397 *U.S.* 471, 485 (1970). See also, *David v. Vesta Co.*, 45 *N.J.* 301, 315 (1965).

The requirement of equal protection is satisfied if all persons within a class reasonably selected are treated alike. And a classification is reasonable if it rests upon some grounds of difference having a real and substantial relation to the basic object of the particular enactment or on some relevant consideration of public policy. If there is a reasonable distinction, there is no oppressive discrimination.

The Legislature has a wide range of discretion in this area and distinctions wil be presumed to rest upon a rational basis if there be any conceivable state of facts which would afford reasonable support for them. *Robson v. Rodriquez*, 26 *N.J.* 517 (1958); *Wilson v. Long Branch*, 27 *N.J.* 360 (1958).

Hence, in assailing the statutory scheme which compels the present difference in rates on the grounds that it violates the equal protection and due process clauses of the Fourteenth Amendment, plaintiffs must carry the burden of showing that the classification which results in favorable benefits to hospital service corporations such as Blue Cross does not bear a reasonable relation to a permissible legislative objective. *West Coast Hotel Co. v. Parrish*, 300 *U.S.* 379, 391 (1937), and is essentially arbitrary. *Goldblatt v. Hempstead*, 369 *U.S.* 590 (1962); *Lindsley v. Natural Carbonic Gas Co.*, 220 *U.S.* 61, 78-79 (1911); *Independent Elec. & Elec. Contractors' Assoc. of N.J. v. N.J. Bd. of Exam. of Elec Cont.*, 54 *N.J.* 466, 473 (1969); *David v. Vesta Co.*, 45 *N.J.* 301, 314-315 (1965). If any state of facts reasonably may be conceived to justify the distinction, the statute will be upheld. *Dandridge v. Williams*, 397 *U.S.* 471, 486-87 (1970); *Metropolitan Casualty Ins. Co. v. Brownell*, 294 *U.S.* 580 (1935).

The state has unquestioned power to legislate in the area of public health. *Williamson v. Lee Optical of Oklahoma, Inc.*, 348 *U.S.* 483 (1955). This is especially so regarding the modern hospital system which is operated for the benefit of the public. See *Griesman v. Newcomb Hospital*, 40 *N.J.* 389, 396 (1963). Equally clear is the fact that, at least in the field of insurance, "the power of the state is broad enough to take over the whole business, leaving no part for private enterprise." *California State Auto. Assoc. Inter-Ins. Bureau v. Maloney*, 341 *U.S.* 105, 110 (1951);

Osborn v. Ozlin, 310 *U.S.* 53 (1940). Not only may the state completely preempt the field of health insurance, but it may affirmatively require the purchase of insurance or its equivalent. *New York Central R. Co. v. White*, 243 *U.S.* 188, 208-09 (1917) (Workmen's Compensation). Alternatively, the state may enact compulsory health insurance supported by employer contributions or by taxes. *See generally, Falk, "National Health Insurance; A Review of Policies and Proposals,"* 37 *L. & Contemp. Prob.* 669 (1970); *Falk, "Beyond Medicare,"* 59 *A.M. J. Pub. Health* 608 (1969). *Cf. Mountain Timber Co. v. Washington*, 243 *U.S.* 219 (1917) (contribution to state fund for Workmen's Compensation).

In New Jersey, rather than preempt the health insurance field entirely, cf. *Independent Service Corp. v. Tousant*, 56 *F. Supp.* 75 (D. Mass. 1944), aff'd 149 *F.2d* 204 (1st Cir. 1945), the Legislature has chosen to enact the Hospital Service Corporation Act (*N.J.S.A.* 17:48-1 *et seq.*) which is designed particularly to accomplish the purpose of a broad based community health program, *i.e.*, to satisfy the needs of the hospitals and the community as a whole through a partnership between hospitals and a non-profit prepayment plan. See *Associated Hospital Service, Inc. v. Milwaukee*, 13 *Wis. 2nd* 447, 109 *N.W. 2d* 271 (Sup. Ct. 1961); *cf. Johnson v. Hospital Service Plan of N. J.*, 25 *N.J.* 134 (1957). *See generally, Report of Special Counsel to the Commissioner of Banking and Insurance of the State of New Jersey For The Public Interest* 30-32 (1970) *(Wharton Report); Final Report of the New Jersey Commission appointed by the Governor to Study Blue Cross in New Jersey* (1967) *(Ward Report); Final Report of the New Jersey Blue Cross Rate Study Commission* 28-30 (1960) *(Simon Report)* ("The basic philosophy of Blue Cross has always been that of constant progress toward the goal of

complete protection against the unpredictable costs of hospital services for all the people of the community".) The goals and objectives of this partnership are (a) to provide to the public a payment-in-advance method for financing care provided by hospitals and to guarantee payment to the hospitals; (b) to make hospital care needed by the public financially accessible to the largest number of people at the lowest possible cost; and (c) to help the community carry the social and economic burden created when people are unable to pay for the necessary care rendered by hospitals. *See generally, Wharton Report* 30-32 (1970). *Johnson v. Hospital Service Plan of N.J.* 25 *N.J.* 134, 144 (1957).

The relationship of the legislative program to these goals is readily apparent from the statutory provisions of the Hospital Service Corporation Act and companion legislation. So, for example, in order to maintain low cost to the public, the statute requires that a hospital service corporation be organized without capital stock and not for profit (17:48-1); that it be operated only for the benefit of its subscribers (17:48-2); that it be strictly limited as to expenditures for solicitation and administration (17:48-10); that its reserves be kept low in contrast to commercial carriers (compare 17:48-10 with 17B:19-5); that its investments be strictly limited (17:48-10); and that it be exempt from most taxes (17:48-18).

When the Hospital Service Corporation Act is read together with the recently enacted Health Care Facilities Planning Act, there emerges an integrated program combining Blue Cross with the entire apparatus for the control of hospital costs under the Commissioners of Health and Insurance. Section 1 of the new Act states:

> "It is hereby declared to be the public policy of the State that hospital and related health care services

> of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health." (*N.J.S.A.* 26: 2H-1)

It is under this Act that the Commissioners of Health and Insurance are given power to determine a "reasonable" rate of reimbursement for the hospitals (*N.J.S.A.* 26:2H-18).

In contrast to the statutorily created tripartite program involving the Commissioners of Insurance and Health, Blue Cross, and the hospitals, commercial health insurance carriers operate for profit and charge whatever premiums and pay whatever benefits they choose subject only to the requirement that benefits to individual subscribers are not unreasonable in relation to the premium charged (17B:26-1 (h) 1). Moreover, a commercial carrier has great freedom to experience rate its group customers, and unlike a hospital service corporation, it is not limited in its right to terminate coverage.

Plaintiff trustees do not constitute either a hospital service corporation or an insurance company. Hence, they are not subject to the strict regulatory statutory controls imposed on hospital service corporations or even to the looser regulations governing insurance companies. They provide benefits to members subject only to general fiduciary principles. Most importantly, the goals and objectives of the plaintiff trustees are not to provide prepayment of hospital care for the community at large or to help the community carry the social and economic burden of such care. Nor is it their function to guarantee payment or insure its prompt receipt by the hospitals. See *Johnson v. Hospital Service Plan of N. J.* 25 *N.J.* 134 (1957).

In *Associated Hospital Service, Inc. v. Milwaukee,* 13 *Wis.* 2d. 447, 109 *N.W.* 2d 271, 88 *A.L.R.* 2d. 1395 (1961),

the Wisconsin Supreme Court considered whether the tax exemption granted the Blue Cross plan resulted in an unreasonable classification violative of the equal protection clause of the Fourteenth Amendment. In particular, the City of Milwaukee argued that an arbitrary and unconstitutional classification is made by the statute in granting exemption to the property of Blue Cross and not that of insurance companies. The court, after discussing the history and background of Blue Cross and the purposes and objectives to which it is dedicated, noted the "marked difference in method of operation between a Blue Cross hospital service corporation and a commercial insurance company that sells hospital care indemnity insurance." 88 *A.L.R.* 2d. at 1411. The court said:

> "The state's interest in protecting the financial status of its state, county, municipal, and voluntary non-profit hospitals is a further justification for treating Blue Cross hospital service corporations differently tax wise than it does commercial insurance companies writing hospital care indemnity insurance." 88 *A.L.R.* 2d. at 1412.

The court concluded:

> "Enough has been said to indicate that the classification made by (the statute) does rest upon real differences existing between non-profit hospital service corporations and commercial insurance companies writing hospital care indemnity insurance. Therefore, such statute does not impose an arbitrary unreasonable classification and is constitutional." Id.

For purposes of this motion it may be assumed *arguendo* that plaintiff trustees, in attempting to provide a health service benefits program to members of the union, are at a

. .

competitive disadvantage vis a vis Blue Cross to the extent that the latter pays less per patient than the plaintiff trustees. However, given the public and quasipublic nature of the entire hospital service corporation system—especially the Blue Cross-member hospital relationship as controlled and regulated by the Commissioners of Health and Insurance—it is apparent that the trustees are complaining of an unequal competitive environment created by and maintained by the state. No constitutional doctrine requires that the state permit free competition or eschew competing with private concerns especially in an area of such public concern as health financing for the community. *Cf. Tennessee Electric Power Co. v. T.V.A.*, 306 *U.S.* 118, 138-40 (1939) (private utility complains of T.V.A. competition and TV.A.'s ability to offer lower rates); *Medera Water Works Co. v. Helena*, 195 *U.S.* 383, 388 (1904); *Joplin v. Southwest Missouri Light Co.*, 191 *U.S.* 150 (1903). *Cf. Hardin v. Kentucky Utility Co.*, 390 *U.S.* 1 (1968) (T.V.A. competition). Indeed, the Government can permit or even destroy such competition. *Missouri Utilities Co. v. California*, 8 *F. Supp.* 454, 465 (W.D. Mo. 1934), appeal dismissed 79 *F. 2d.* 1003 (8th Cir. 1935).

Notwithstanding its power to do so, in creating hospital service corporations and in regulating their reimbursement of hospitals, the State of New Jersey has not sought to forbid or destroy competition among other organizations wishing to provide health insurance or health service benefits. Neither has the state required all persons to purchase Blue Cross insurance or forbidden others to act as third party payors. Rather the statute creating the Blue Cross program provides certain benefits to and imposes certain burdens on Blue Cross so as to enable it to accomplish its statutory purposes. The fact that in so doing the plaintiff trustees' welfare plan has been put at a competitive disadvantage does no violence to the Constitution. *Cf. Independent Service Corp. v. Tousant*, 56 *F. Supp.* 75 (D. Mass. 1944), aff'd. 149 *F. 2d.* 204 (1st Cir. 1945). See also *Virgo Corp. v. Paiewonsky*, 384 *F. 2d* 569 (3d Cir. 1967), *cert denied* 390 *U.S.* 1041 (1968) (one of four competitors may be denied subsidies granted to others where, in view of public purpose of subsidy program, classification was not "patently arbitrary").

THE CONSTITUTIONAL ISSUE ARISING UNDER ARTICLE I, PARAGRAPH 19 OF THE NEW JERSEY CONSTITUTION WHICH GUARANTEES THE RIGHTS OF EMPLOYEES TO ORGANIZE AND BARGAIN COLLECTIVELY.

The pertient part of the constitutional provision referred to above states:

> "Persons in private employment shall have the right to organize and bargain collectively".

Plaintiffs assert that their right to organize and bargain collectively has been infringed upon but how it has been infringed upon by the hospitals and Blue Cross is not explained. In my judgment, the constitutional guarantee of the right of persons in private employment to organize and bargain collectively has no application to the dispute between the parties in this case. The relationship of employer and employee does exist between the hospitals, Blue Cross and the plaintiffs. The gravamen of a right to collective bargaining rests upon an employee-employer relationship. Compare *Johnson v. Christ Hospital*, 84 *N.J. Super.* 541 (Ch. Div. 1964), aff'd. 45 *N.J.* 108 (1965).

Neither the industry of counsel nor of this Court has turned up a case in New Jersey or in Federal Law whereby a third party not involved in labor negotiations has been

held bound by the provisions of Article I, Paragraph 19 of the New Jersey Constitution.

THE NEW JERSEY ANTI-TRUST ACT, *N.J.S.A.* 56:9-1, *et seq.* HAS NO APPLICATION IN THIS CASE.

Section 3 of the above Act provides:

"Every contract, combination in the form of trust, or otherwise, or conspiracy in restraint of trade or commerce in this State shall be unlawful".

Plaintiffs assert:

"The defendant hospitals have conspired with the officers, employees and directors of Blue Cross in furtherance of a common plan and a mutual scheme in violation of the New Jersey Anti-Trust Act in charging the plaintiffs and members of all other welfare unions similarly situated more than subscribers of defendant Blue Cross are required to pay for the same equipment, facilities and services, thereby depriving plaintiff and members of their class of their property by reason of such acts, consipracy, common plan, mutual scheme and monopolization in violation of the provisions of the New Jersey Anti-Trust Law".

The New Jersey Anti-Trust Act, *N.J.S.A.* 56:9-12 also provides:

"(a). Any person who shall be injured in his business or property by reason of a violation of the provisions of this act may sue therefor and shall recover threefold the damages sustained by him, together with reasonable attorneys' fees, filing fees and reasonable costs of suit. Reasonable costs of suit may include, but shall not be limited to the expenses of discovery and document reproduction".

Based upon the authority of the above section, the plaintiffs for themselves and for each member of the contemplated class seek treble damages together with reasonable attorneys' fees, filing fees and reasonable costs of suit.

In my judgment, the New Jersey Anti-Trust Act has no application in this controversy for the following reasons:

(1) I have heretofore pointed out that plaintiffs allege no facts to support their contention that the defendant hospitals have conspired with the officers, members and directors of Blue Cross in furtherance of a common plan, a mutual scheme and monopolization in violation of the New Jersey Anti-Trust Act. Plaintiffs charge conspiracy but tacitly admit that the charge is based upon no known facts. In plaintiffs' brief, reference is made to "the unknown factual questions" which necessitate and warrant discovery and stem from the first negotiations between New Jersey hospitals and Blue Cross whereby a formula is determined and agreed upon between the parties which is then used to calculate the per diem rate to the charged Blue Cross subscribers *after approval by the Commissioners of Insurance and Health.*

Even assuming, as plaintiffs charge, that a formula is determined and agreed upon between the parties which is then used to calculate the per diem rate to be charged Blue Cross subscribers *after approval by the Commissioners of Insurance and Health*, it is not conceivable how those negotiations and the resultant formulas in which the State of New Jersey, through the Commissioner of Insurance and the Commissioner of Health participates, constitute a violation of the New Jersey Anti-Trust Act.

(2) The Anti-Trust Act provides that:

"*Charitable Exemption:* 'No provisions of this Act shall be construed to make illegal:

• • •

"'(5) The bona fide religious and charitable activities of any not for profit corporation . . . established exclusively for religious or charitable purposes, or for both purposes'". *N.J.S.A.* 56:9-5(b)

All but one of the defendant hospitals come within this class of organization.

Plaintiffs' brief offers no reason or authority to support its bare statement that defendant hospitals should be denied the exemption for which the statute specifically provides.

(3) *Insurance Exemption.* Blue Cross and the rate of Blue Cross reimbursement to hospitals are subject to detailed regulation by the Commissioner of Insurance. As such, the establishment of the payment rates to which plaintiffs object is exempt from New Jersey's Anti-Trust Act, which provides:

"No provisions of this Act shall be construed to make illegal:

• • •

"(4) The activities . . . of any insurer . . . to the extent that such activities are subject to regulation by the Commissioner of Insurance of this State under, or are permitted, or are authorized by, the Department of Banking and Insurance Act of 1948 (C. 17:1-1 et seq.) and the Department of Insurance Act of 1970 (C. 17:1C-1 et seq.)" *N.J.S.A.* 56:9-5(b)(4).

Plaintiffs argue that Blue Cross is not an "insurer" within the meaning of this exemption, citing cases which define

"insurer" in contexts outside of the anti-trust field and which, therefore, are not pertinent.

The determination of whether or not Blue Cross is an insurer within the meaning of the Anti-Trust Act exemption must be determined in light of the purpose of the exemption. Clearly the exemption is designed to avoid the situation whereby a state regulatory agency acting pursuant to one statute (the insurance laws) requires conduct which might be held to violate another statute (the Anti-Trust Act).

With the purpose of the anti-trust exemption language in mind, the cases follow a consistent pattern. In that context, Blue Cross organizations regulated by an insurance commissioner are deemed to be insurers and exempt from anti-trust provisions.

To hold otherwise would be contrary to established principles of statutory construction, for then acts which the Commissioner is authorized and directed to perform under *N.J.S.A.* 17:48-1, *et seq.*, regulating hospital service corporations would be prohibited by *N.J.S.A.* 56:9-1, *et seq.* A statute is not to be construed in such a way that it will render other legislative acts vain or impotent. *State v. McCall,* 14 *N.J.* 538, 103 *A. 2d.* 376 (1954); *Loftus v. Public Service Interstate Transp. Co.,* 26 *N.J. Misc.* 246, 59 A 2d. 652 (Sup.Ct. 1948).

Even without a specific exemption for insurers, the Wisconsin Supreme Court held that Wisconsin Blue Cross, which received a discount from contracting hospitals, did not violate the state anti-trust laws. The Court reasoned that the federal "rule of reason" test should be used in construing the Wisconsin Anti-Trust Law because it had previously been held that the state law was a re-enactment of the Sherman Act for intrastate transactions. Applying

the rule of reason test, the Court held that to violate the state anti-trust law the alleged restraint on trade must be unreasonable, and the restraint in this case was not unreasonable because it was authorized by state laws which clearly fulfilled the legislative intent behind their enactment. *Reese v. Associated Hospital Service, Inc.*, 45 *Wisc.* 2d. 526, 173 (N.W. 2d. 661 (Supp. Ct. 1970).

The application of the McCarren Act, 15 *U.S.C.A.* Sec. 1011-1015, to hospital service corporations compels the conclusion that such a corporation is an "insurer" for the purpose of exemption provisions of anti-trust laws and the contracts establishing hospital reimbursement rates are entered into in the course of an insurer's business.

The McCarren Act provides that the business of insurance and the persons engaged therein shall be subject to the laws of the several states which regulate such business and that the federal anti-trust laws shall be applicable to the business of insurance only to the extent that such business is not regulated by state law (except that the Sherman Act shall continue to apply to boycotts, coercion and intimidation).

In *Traveler's Insurance Co. v. Blue Cross of Western Pa.*, CCH Trade Reg. Rep. Para. 73, 811 (W.D.Penna. 1972) plaintiff insurance company sued Blue Cross under the federal anti-trust laws. The facts were very similar to those in the present case. The hospitals under contract with Blue Cross charged plaintiff and other commercial carriers an average of 14% more for their services than they accepted as full payment from Blue Cross. The activities of Blue Cross, including the contracts for reimbursement, were regulated by the Pennsylvania Insurance Department pursuant to statute.

Blue Cross claimed that it was in the business of insurance and therefore exempt from the federal anti-trust laws by virtue of the McCarren Act. Agreeing with this position, the Court stated:

> ". . . The Blue Cross hospital contract is, therefore, an integral part of Pennsylvania's regulated hospital plan. By reason of the interrelationship of hospital payments and Blue Cross subscriber rates the contract also falls within the ambit of 'insurance business'".

Further, Blue Cross denied that it had engaged in any acts which constituted monopolization or restraint of trade within the meaning of the Sherman Act. As in the present case, the heart of the plaintiff's case was the "discriminatory price advantage emanating from Blue Cross' contract with hospitals". The Court held not only that Blue Cross was exempt from the anti-trust act by virtue of the McCarren Act, it also held that in any event there was no restraint of trade or monopolization in violation of the Sherman Anti-Trust Act.

Motion for Summary Judgment in favor of the defendant hospitals, and the Hospital Service Plan of New Jersey (Blue Cross), is granted.

ORDER FOR SUMMARY JUDGMENT
(Filed March 12, 1973)

This matter having been brought before the court by the defendant hospitals upon a motion to dismiss the complaint as to them, which motion, in accordance with R. 4:6-2, has been treated as a motion for summary judgment, and by the defendant Hospital Service Plan of New Jersey upon motion for summary judgment in said defendant's favor against plaintiffs; and the court having read and considered the affidavits and briefs filed by the defendant hospitals and by the plaintiffs, and the court having heard and considered the arguments of counsel; and the court having rendered an opinion on January 22, 1973; and it appearing to the court that there are no genuine issues as to any material facts and that defendant hospitals and defendant Hospital Service Plan of New Jersey are entitled to judgment against plaintiffs on defendants' motions for summary judgment, as a matter of law; and the court having determined that there is no just reason for delay; and good cause appearing;

IT IS on this 9th day of March, 1973 ORDERED that the motions for summary judgment in favor of defendant hospitals and defendant Hospital Service Plan of New Jersey be and they hereby are granted and final judgment be and hereby is rendered and directed to be entered in favor of defendant hospitals and defendant Hospital Service Plan of New Jersey against plaintiffs with prejudice.

/s/ Alfred A. Fink
ALFRED A. FINK, J.S.C.

NOTICE OF APPEAL TO APPELLATE DIVISION

TO: Judge A. Alfred Fink
Superior Court
Hudson County
Chancery Division
Administration Building
595 Newark Avenue, Jersey City, N.J. 07306

SMITH, STRATTON, WISE & HEHER, Esqs.
Attorneys for Defendant Bayonne Hospital
1 Palmer Square, Princeton, N.J.

HERBERT ALTERMAN, Esq.
Attorney for Defendant Beth Israel Hospital
663 Main Avenue, Passaic, N.J.

LEBSON & PRIGOFF, Esqs.
Attorneys for Defendant Englewood Hospital Association
39 Park Place, Englewood, N.J.

WINNE & BANTA, Esqs.
Attorneys for Defendant Hackensack Hospital Association
25 East Salem Street, Hackensack, N.J.

MICHAEL J. FARRARA, Esq.
Attorney for Defendant Bergen Pines County Hospital
166 Main Street, Hackensack, N.J.

SMITH, KRAMER & MORRISON, Esqs.
Attorneys for Defendant Clara Maass Memorial Hospital
810 Broad Street, Newark, N.J.

MORRISON & GRIGGS, Esqs.
Attorneys for Defendant Greater Paterson General Hospital Association
210 Main Street, Hackensack, N.J.

BRESLIN & BRESLIN, Esqs.
Attorneys for Defendant Holy Name Hospital
41 Main Street, Hackensack, N.J.

RIKER, DANZIG, SCHERER & BROWN, Esqs.
Attorneys for Defendants The Hospital Center at Orange and Saint Barnabas Medical Center
744 Broad Street, Newark, N.J.

GIORDANO, GIORDANO & HALLERAN, Esqs.
Attorneys for Defendant Monmouth Medical Center
Highway 35, Middletown, N. J.

BOOTH, BUERMANN & RATE, Esqs.
Attorneys for Defendant Mountainside Hospital
31 Park Street, Montclair, N.J.

CLAPP & EISENBERG, Esqs.
Attorneys for Defendant Riverdell Hospital
744 Broad Street, Newark, N.J.

WILENTZ, GOLDMAN & SPITZER, Esqs.
Attorneys for Defendant South Amboy Memorial Hospital
252 Madison Avenue, Perth Amboy, N.J.

JOHNSON, JOHNSON & MORPHY, Esqs.
Attorneys for Defendant St. Joseph's Hospital
401 Wanaque Avenue, Pomptom Lakes, N.J.

KEIN, POLLATSCHEK & IACOPINO, Esqs.
Attorneys for Defendant Irvington General Hospital
1000 Stuyvesant Avenue, Union, N.J.

SCHENCK, PRICE, SMITH & KING, Esqs.
Attorneys for Defendant Morristown Memorial
10 Washington Street, Morristown, N.J.

LOWENSTEIN, SANDLER, BROCHIN, KOHL & FISHER, Esqs.
Attorneys for Defendant Newark Beth Israel Medical Center
744 Broad Street, Newark, N.J.

JOHN F. McCANN, Esq.
Attorney for Defendant Saddle Brook Hospital
291 Main Street, Ridgefield, N.J.

MILTON, KEANE & BRADY, Esqs.
Attorneys for Defendants St. Michael's Medical Center and St. Mary's Hospital of Hoboken
40 Journal Square, Jersey City, N.J.

MANDAK, ROTH & FERRANTE, Esqs.
Attorneys for Defendant St. Mary's Hospital of Passaic
415 Clifton Avenue, Clifton, N.J.

STEPHEN R. BOLSON
Deputy Attorney General of New Jersey
Attorney for Defendants New Jersey Commissioners of Insurance & Health
State House, Trenton, N.J. 08625

PITNEY, HARDIN & KIPP, Esqs.
Attorneys for Defendant Hospital Service Plan of New Jersey
570 Broad Street, Newark, N.J. 07102

SIRS:

Notice is hereby given that Plaintiff, John Borland, Jr., et al., appeals to the Appellate Division of the Superior

Court of New Jersey, from the Final Judgment of the Superior Court, Hudson County, Chancery Division (Judge A. Alfred Fink) entered only in favor of the Defendant, Hospital Service Plan of New Jersey, and the Defendant Hospitals in this action, on March 9th, 1973.

The Plaintiff has ordered a copy of the transcript on January 5th, 1973, the original having been filed with the Superior Court.

KRIEGER & CHODASH
Attorneys for Plaintiff

By: /s/ Harold Krieger
HAROLD KRIEGER

DATED: April 13, 1973

NOTICE OF MOTION OF COMMISSIONERS OF HEALTH AND INSURANCE TO TRANSFER THE CASE TO THE APPELLATE DIVISION

SIRS:

PLEASE TAKE NOTICE that on Friday, June 29, 1973, at 9:00 A.M., or as soon thereafter as counsel may be heard, the undersigned attorney for defendants, Richard C. McDonough and James R. Cowan, will make application to the Superior Court of New Jersey, Chancery Division, sitting in Jersey City, at the Court House Administrative Building, Jersey City, New Jersey for an order transferring this matter to the Appellate Division on the grounds that this matter concerns an appeal from a final determination by an administrative agency, which is appealable as of right to the Appellate Division.

TAKE FURTHER NOTICE that in support of the within Motion, the undersigned shall rely upon the brief submitted herewith.

GEORGE F. KUGLER, JR.
Attorney General of
New Jersey
Attorney for Defendants

By: /s/ Steven R. Bolson
STEVEN R. BOLSON
Deputy Attorney General

Dated: June 5, 1973

STATEMENTS

The originals of the within Motion to Transfer the Case to the Appellate Division have been sent for filing to the Clerk of the Superior Court.

s/ Steven R. Bolson
STEVEN R. BOLSON

A clear copy of the within Motion to Transfer the Case to the Appellate Division has been sent for filing to Judge Alfred A. Fink, Court House Administration Building, Jersey City, New Jersey.

s/ Steven R. Bolson
STEVEN R. BOLSON

CERTIFICATE OF SERVICE

I hereby certify that on this date copies of the Motion to Transfer the Case to the Appellate Division were served upon all other counsel of record in this matter by mailing same, first class mail, postage prepaid, at Trenton, New Jersey, addressed to their respective offices.

s/ Steven R. Bolson
STEVEN R. BOLSON

Dated: June 5, 1973

ORDER TO TRANSFER TO APPELLATE DIVISION

This matter being opened to the Court by George F. Kugler, Jr., Attorney General of New Jersey (by Steven R. Bolson, then Deputy Attorney General, on the brief and by Omer F. Brown, II, Deputy Attorney General appearing,) attorney for defendants Richard C. McDonough, Commissioner of Insurance and James R. Cowan, Commissioner of Health, and the Court having examined the briefs of defendant Commissioners and of plaintiffs filed herein and heard the arguments of counsel for defendant commissioners and for plaintiffs, and good cause appearing therefore,

IT IS on this 19th day of October, 1973,

ORDERED:

That this cause of action be transferred to the Appellate Division of the Superior Court in accordance with R. 1:13-4 (a) by virtue of R. 2:2-3 (a).

/s/ Sidney M. Schreiber
SIDNEY M. SCHREIBER,
J.S.C.

ORDER OF THIS COURT FOR REMAND ENTERED JANUARY 22, 1974

(Filed January 24, 1974)

Moving Papers Filed–December 26, 1973
Answering Papers Filed–January 7, 1974
Date Submitted to Court–January 8, 1974
Date Argued–
Date Decided–January 22, 1974

ORDER

This matter having been duly presented to the Court, it is hereby ORDERED as follows:

Motion for Taking of Depositions
Granted Denied X Other X

SUPPLEMENTAL:

(1) The motion to take depositions is denied.

(2) The matter is remanded to the Commissioner of Insurance for the purpose of expanding the record particularly with respect to the method used and the factors considered by him in establishing the rates payable by the Hospital Service Plan of New Jersey (Blue Cross and Blue Shield), as required by *N.J.S.A.* 26:2H-18. When completed the same shall be filed as part of the record on this appeal.

I hereby certify that the foregoing is a true copy of the original on file in my office.
Mortimer E. Newman, Jr., Clerk

FOR THE COURT:
/s/ Joseph Halpern
P.J.A.D.

Witness, the Honorable Joseph Halpern, Presiding Judge of Part E, Superior Court of New Jersey, Appellate Division, this 22nd day of January 197 .

ORDER OF THIS COURT DATED JULY 8, 1974 TO HAVE COMMISSIONERS COMPLY WITH PRIOR ORDER ENTERED JANUARY 22, 1974

(Filed July 11, 1974)

Moving Papers Filed–June 17, 1974
Answering Papers Filed–June 27, 1974
Date Submitted to Court–July 3, 1974
Date Argued–
Date Decided–July 8, 1974

ORDER

This matter having been duly presented to the court, it is hereby ordered as follows:

Motion to Comply with Order of January 22, 1974
Granted– Denied– OtherX

SUPPLEMENTAL:

The Commissioner of Insurance shall comply with our order of January 24, 1974, on or before September 9, 1974.

I hereby certify that the foregoing
is a true copy of the original on file
in my office.

/s/ Elizabeth McLaughlin
Clerk

FOR THE COURT:
/s/ John W. Fritz
JOHN W. FRITZ, P.J.A.D.

Witness, the Honorable John W. Fritz, presiding Judge of part N, Superior Court of New Jersey, Appellate Division, this 8th day of July, 1974.

/s/ Elizabeth McLaughlin
Clerk of the Appellate Division

PLAINTIFF'S MOTION TO ORDER THE COMMISSIONERS TO COMPLY WITH THE TWO ORDERS OF THIS COURT

TO: GEORGE F. KUGLER, JR.
Attorney General of New Jersey
Attorney for Defendants-Respondents
State House Annex
Trenton, New Jersey 08625

SIR:

PLEASE TAKE NOTICE that the plaintiff-appellant now makes application to this Court for an Order requiring the Commissioner of Insurance, James J. Sheeran, to comply with the Order made by this Court on the 22nd day of January, 1974, copy of which is attached hereto and marked Exhibit "A", as reaffirmed by the Order of this Court dated July 8, 1974, wherein the Court Ordered that "the Commissioner of Insurance shall comply with our Order of January 24, 1974", on or before September 9, 1974, a copy of which is attached hereto and is marked as Exhibit "B".

More particularly, the plaintiffs-appellants feels that the "EXPANSION OF THE RECORD ON REMAND" is defective and/or defecient in the following respects:

1. The material furnished did not indicate how the final limitation on the amount of per diem payable by Blue Cross was established.

2. There is no explanation or justification given for item G(e) appearing on page 18(a).

3. There is no explanation for the limitation on the amount of expense absorbed by Blue Cross relating to computer operations.

4. The expanded record is obscure as to the extent that bad debts are included in the total costs upon which Blue Cross payments are made.

5. There is no explanation of why non-Blue Cross non-governmental per diem charges exceed Blue Cross by approximately 20%, when *N.J.S.A.* 26:2H-18 dictates that *all costs* must be included in the Blue Cross rates.

6. The "EXPANSION OF THE RECORD ON REMAND" is defective in form inasmuch as it does not state findings of fact or conclusions of law as made by the Commissioner.

This Motion is supported by the attached Affidavit and Memorandum.

Respectfully submitted,
KRIEGER & CHODASH
By: /s/ Harold Krieger
HAROLD KRIEGER

Dated: December 16, 1974

ORDER OF THIS COURT DATED JANUARY 7, 1975 DENYING MOTION

(Filed January 9, 1975)

Moving Papers Filed–December 19, 1974

Answering Papers Filed–January 2, 1975

Date Submitted to Court–January 6, 1975

Date Argued–

Date Decided–January 7, 1975

ORDER

This matter having been duly presented to the court, it is hereby ordered as follows:

Motion to Comply with Order of the Court
Granted– Denied X Other–

SUPPLEMENTAL:

I hereby certify that the foregoing
is a true copy of the original on file
In my office.

Elizabeth McLaughlin, Clerk

FOR THE COURT:

/s/ Robert A. Matthews
ROBERT A. MATTHEWS
P.J.A.D.

Witness, the Honorable Robert A. Matthews, presiding Judge of Part G, Superior Court of New Jersey, Appellate Division, this 7th day of January 1975.

Elizabeth McLaughlin
Clerk of the Appellate Division

HOSPITAL INVOICE FOR BLUE CROSS SUBSCRIBERS SHOWING "DISCOUNT"

	Charges	Credits	Amount
76 days @ $135.00 S.P.	$10,260.00		
1 day @ 69.00 S.P.	69.00		
1 day @ 71.00 S.P.	71.00		
oxygen	84.00		
blood gas studies	798.00		
med. & surg. supplies	160.50		
intravenous solutions	98.75		
drugs & medications	570.75		
laboratory	3,693.50		
blood	100.00		
admin. blood-plasma	30.00		
x-rays	231.25		
bill breakdown	4.00		$16,170.75
Paid by patient		$ 4.00	
Paid by N J Hospital Plan		8,057.40	
Difference absorbed by Hospital		8,009.35	
Blood replacement		100.00	$ .00

FIRST AFFIDAVIT OF FRED WILLIAMS

FRED WILLIAMS, of full age, being duly sworn upon his oath deposes and says:

1. I am employed by Local 464 of the Amalgamated Meat Cutters and Food Store Employees Union and I am fully aware of and involved in all aspects of administering the Welfare Fund of Local 464, including specific hospital charges.

2. Daniel Webster, a member of the Welfare Fund, who was also covered under the New Jersey Hospital Plan's coverage, compiled a total bill at Newark Beth Israel Medical Center of February 25, 1972. Of this total bill only $8,057.40 was paid by the New Jersey Hospital plan, while $8,009.35 was "absorbed by the Hospital" as stated in their invoice of April 25, 1972.

3. This "absorbtion by the Hospital" is the result of the exclusion of certain legitimate expenses from the reimbursement formula applied to Blue Cross subscribers with the result that these expenses must be charged to and shared by the remainder of the patients who are not Blue Cross members. This inequitable system results in Blue Cross being charged less than its fair share of the hospital's costs. All others, including members of the Local 464 Welfare Fund, are charged more than their fair share.

4. This inequitable situation is emphasized by reference to a specific example. Howard Marks, a member of the Welfare Fund of Local 464, while a patient at Bayonne Hospital, was billed at a per diem rate of $65.00 per day for a semi-private room on, or about April, 1971. The per diem rate charged Blue Cross members for the same or similar services at this time was approximately 20% less than the rate charged Mr. Marks as a non-Blue Cross subscriber.

/s/ Fred Williams

NOTARIZED.

SECOND AFFIDAVIT OF FRED WILLIAMS

STATE OF NEW JERSEY)
) SS.
COUNTY OF HUDSON)

FRED WILLIAMS, of full age, being duly sworn upon his oath deposes and says:

1. I am employed by Local 464 of the Amalgamated Meat Cutters and Food Store Employees Union and I am fully aware of and involved in all aspects of administering the Welfare Fund of Local 464, including specific hospital charges.

2. In adidtion thereto, I am aware of the policy concerning charges by hospitals in New Jersey to Blue Cross subscribers, concerning calculation of per diem rates, and the discriminatory practices employed by said hospitals and Blue Cross (New Jersey Hospital Plan) in arriving at these rates by arbitrarily excluding certain cost items.

3. I would like to repeat, reiterate, and make a part hereof the specific instances outlined in my first Affidavit (Affidavit I–see attached) which indicates the discriminatory rate charges that are employed by New Jersey Hospitals to non-Blue Cross subscribers. (See attached bills)

4. The discriminatory rate scheme is an accepted fact today; however, the fact that remains unknown is the method employed by New Jersey hospitals, in conjunction with Blue Cross and with the State of New Jersey, its Commissioners of Insurance and Health as overseers, in arriving at said rate.

5. The secrecy of the negotiations between Blue Cross and New Jersey Hospitals in calculation of their formula which determines the rates to be charged Blue Cross,

which as a result also fixes the high discriminatory rate charged to non-Blue Cross subscribers, has denied the Union Welfare Fund the opportunity of knowing exactly what specific cost items are included or excluded in the calculation of the Blue Cross formula.

6. I know that certain cost items are arbitrarily excluded from the calculation of Blue Cross formula, but it is not known specifically which items are excluded or included and the rational purpose, if any, for such exclusion!

7. What costs from the *total* hospital operating costs are excluded or included? What about other expense items? What losses are incurred, totally and individually per Blue Cross patient as a result of such arbitrary exclusion, thereby necessitating this loss to be passed on to non-Blue Cross patients?

8. These questions of fact must be answered to enable a determination to be made as to the rationality of such arbitrary action. Therefore, discovery must be allowed to enable the legality of such practices to be exposed.

/s/ Fred Williams
FRED WILLIAMS

NOTARIZED.

MEMORANDUM OF LAW SUBMITTED BY PLAINTIFFS IN SUPPORT OF THEIR MOTION TO HAVE THE COMMISSIONERS COMPLY WITH THE PRIOR ORDERS OF THE COURT, INCLUDING AFFIDAVIT

II. Appellants' motion for an order requiring the Commissioner of Insurance to comply with its orders of January 22, 1974 and of July 8, 1974, should be granted

Procedural History

and

Statements of the Facts

In lieu of a duplicitous statement, the appellants incorporate and make a part hereof, a copy of their Attorneys' Affidavit in Support of the Motion.

ARGUMENT

The appellants respectfully submit that the Commissioner of Insurance has not only failed to comply with its twice-issued Order, but that he has failed to address himself to same.

N.J.S.A. 26:2H-17(d) reads as follows:

> Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In *establishing* such rates, the commissioners shall take into consideration the total costs of the health care facility. (L.1971, c.136 § 18, approved May 10, 1971. (emphasis added)

Thus, this Court has twice Ordered that:

"... (2) The matter is remanded to the Commissioner of Insurance for the purpose of expanding the record particularly with respect to the method used and the factors considered by him in *establishing* the rates payable by the Hospital Service Plan of New Jersey (Blue Cross and Blue Shield), as required by *N.J.S.A.* 26:2H-18. When completed the same shall be filed as part of the record on this appeal."

Yet, the Attorney General, in his brief on behalf of the Commissioner, states that the "Expanded Record" . . . "is responsive to the court's remand order in that it provides a comprehensive statement of, *inter alia*, the method used and the factors considered in *approving* reimbursement rates payable by the Hospital Service Plan of New Jersey as required by *N.J.S.A.* 26:2H-18 and *N.J.S.A.* 17:48-7."

The appellants submit that the Expanded Record is *not* responsive to the Court's Order and they, therefore, respectfully submit that if the Commissioner felt that he could not comply with the language of the Order, then he should have objected to the form of the Order so that this matter could proceed in due course.

In *arguendo*, assuming that the expanded record was properly addressed to the Orders, the appellants must urge that such record, as expanded, is incomplete and otherwise defective.

In page 5 of the Attorney General's brief, it is stated that the record ". . . dispels the misconception that the Commissioners do not take into account the *total costs* of hospitals *as required* by *N.J.S.A.* 26:2H-18(d)." (emphasis added)

Thus, we have a tacit admission by the Commissioner that he has an obligation to take into consideration the

total costs of health care facilities. However, on page 19 of the expanded record it is stated that the total expenses of the hospital is used only as a "starting point" for any reimbursement calculation.

It is further stated on the same page:

"This is *reduced* in the Contracting Agreement, by costs which are inappropriate for reimbursement purposes. At Budget Review, the budgeted expenses may be *further reduced* by amounts which, it is felt, a hospital need not spend to provide efficient, high quality health care services—the expectation is that the hospital, so notified in advance, will in fact not incur these unnecessary costs. Finally, the hospital may be *denied reimbursement* of actual expenses following cost review, if those costs have exceeded the Budget Review recommendations. The purpose of this is not to save money for Blue Cross and its subscribers, but rather to limit payments to amounts that were agreed, in advance, should constitute "reasonable" expenses as required by statute." (emphasis added)

Nowhere in the expanded record is there any authority cited for such a procedure.

Nowhere are there any itemization or enumeration of *which* costs are deemed "inappropriate" and therefore excluded.

Nowhere is the regulations and procedure described whereby such costs are determined "in advance" to be "inappropriate."

Nowhere is it stated who makes such determinations, and who has the authority to do so.

Nowhere is there any record that could support the "expectation" that "the hospital so notified in advance, will in fact not incur these unnecessary costs."

Furthermore, we have no idea if such things are determined at meetings; if so, by whom they are attended, and whether or not there are any minutes of same.

Thus it seems quite clear that the" expanded record" is incomplete and defective" and the appellants therefore strongly feel that this appeal is not ready for consideration on the merits.

More particularly, commencing on page 3 of appellants' attorneys' affidavit made in support of their motion and made a part hereof, counsel carefully enumerated and graphically detailed specific objections to the "record" which should render same incomplete and defective. It is respectfully submitted that the brief filed by the office of the Attorney General has not even addressed itself to these specific objections, apparently choosing to ignore same. The appellants most respectfully urge this Court to carefully scrutinize these specific objections, and make its own finding as to their significance.

The appellants feel very strongly that this matter must proceed, but we must first have a foundation, a common base of settled facts, without which there cannot be a final determination on the merits.

The appellants further submit that this record is not only important for this appeal but, it is also necessary for the companion case #A-2210-72, which appeal has been fully briefed by all the parties and, as ordered by the court, will be heard on the same day, one to follow the other.

CONCLUSION

For the reasons stated herein, the Court should grant appellants' two motions.

Respectfully submitted,
KRIEGER & CHODASH
Attorneys for Appellants
/s/ David Feinsilver
DAVID FEINSILVER

STATE OF NEW JERSEY:
SS:
COUNTY OF HUDSON :

HAROLD KRIEGER, being duly sworn acording to law, upon his oath, deposes and says:

1. I am a partner in the law firm of Krieger & Chodash, attorneys for the plaintiff-appellant.

2. An action was instituted on behalf of the plaintiff-appellant in the Superior Court of New Jersey, Chancery Division and among the defendants were the Commissioner of Health and the Commissioner of Insurance. The defendant hospitals and the Hospital Service Plan of New Jersey made a motion for Summary Judgment which Motion was granted.

3. A motion was made requiring the Commisioner of Insurance to complete the record by the taking of depositions, the motion was filed on December 26, 1973, and decided on January 2, 1974. On that date, the Court Ordered the Commissioner to expand the record particularly with respect to the method used and the factors *considered by him* in establishing the rates payable by the Hospital Service Plan of New Jersey (Blue Cross and Blue Shield) as required by N.J.S.A. 26:2H-18 . . ." which statute requires that *all costs* be included in fixing or approving rates.

4. On July 8, 1974, this Court again Ordered that "the Commissioner of Insurance shall comply with our Order of January 24, 1974," on or before September 9, 1974.

5. Pursuant to the latter Order on or about September 6, 1974, the Commissioner of Insurance filed with the Court an "EXPANSION OF THE RECORD ON REMAND."

6. It is the position of the plaintiffs that the aforementioned "EXPANSION OF THE RECORD ON REMAND" is deficient in the following respects:

1. The material furnished did not indicate how the final limitation on the amount of per diem payable (as described on page 8) was established. It therein appears that on a tentative rate basis the maximum rate would be the average rates of the highest 10% of the participating hospitals. For those in the upper half of the 10%, this process would mean that they are not being paid the cost of providing services. We therefore request a further explanation of this process.

2. As stated on page 18a, Item G(e) of the material provided

> "It is not contemplated that the Plan will be responsible for costs of capital debt that are excessive either as to the size of the debt incurred compared to the equity support given by sponsors of the facility or as to the rate of interest paid thereon. To implement this objective the amount of interest on capital debt included in reimbursable costs for any year should not exceed an amount arrived at by applying a percentage to the original cost value of the entire plant assets of the hospital. This percentage is to be determined by adding 1½% to the "prime" rate of interest existing at the time the indebtedness was incurred and multiplying this amount by 50%."

It appears that the implementation of this provision can have significant financial repercussions to an individual hospital, resulting in costs not being covered by the Blue Cross reimbursement formula. We therefore request a further explanation of this provision.

3. It appears from the "EXPANSION OF THE RECORD ON REMAND," that there is an unjustified limitation on the amount of expense absorbed by Blue Cross, relating to computer operations. As a consequence thereof, individual hospitals may very well have administrative costs that are wrongfully not being paid by Blue Cross. We therefore request a further explanation for the formula as used.

4. Perhaps the area where in the factual and legal bases are most occluded is that dealing with bad debts. This is a very substantial item, particularly in hospitals such as those located in center-cities, where a significant proportion of the patients do not pay. Such items must be broken down into three parts:

a) *Emergency out-patient treatment.* As indicated in the paragraph in the middle of page 17, a hospital may include the emergency room indigent loss in total reimbursable expenses, which results in Schedule V-B in Blue Cross paying "its share" based on its proportion of in-patient days But some in-patients do not pay. Therefore, no share of the emergency out-patient losses is borne by this non-paying in-patients. The net result, of course, is that the hospital either loses money or charges the paying non-Blue Cross in-patients more than their proportionate share of the emergency out-patient losses.

b) *Non-emergency out-patient losses.* This is described in the paragraph that runs from the bottom of page 17 to the top of page 18. We question the validity of the assumption that charges for such services are set at a level sufficient to cover indigent losses and bad debts arising from out-patients. If we read this paragraph correctly, Blue Cross does not pay its proportionate share of the non-emergency out-patient losses.

c) *In-patient indigent losses and bad debts.* It appears quite clear that Blue Cross does not pay its proportionate share of this item. Line X of Schedule 1 and Schedule 111 C indicate that they reimburse only for the bad debts resulting from New Jersey Blue Cross in-patients.

Inasmuch as bad debts present serious budgetary problems for almost all hospitals, we must herefore request that the Commissioner's consideration of same, pursuant to *N.J.S.A.* 26:2H-18, be described in further detail, especially since the broad question of what is Blue Cross's proper proportionate share (of bad debt expenses and/or losses), appears either to have been answered by assumption or conjecture, or perhaps even ignored.

By way of example, we offer the following:

1. On page 17, it is stated that there are indications that the additional revenues from Blue Cross subscribers who "choose" to occupy a private room may exceed in-patient indigent losses for most New Jersey hospitals. The validity of this statement may be questioned. What about the private-room patient who did not choose it?

Our information, obtained through direct calls to a number of hospitals, indicates that the proportion of private beds to total beds is so small that their use by Blue Cross patients could not make a contribution to hospital revenue equal to the cost of indigent care.

The following information was gained:

	Total Beds	Private Beds
St. Barnabas	668	25
Monmouth Medical Center	450	22
Hackensack Hospital	450	46
Muhlenberg Hospital	430	20

2. Also, as mentioned above, there is the question of who pays for the out-patient losses, particularly the non-emergency.

A simple hypothetical numerical example will illustrate this. Suppose that a hospital's total in-patient days are distributed as follows:

Medicare	25%
Medicaid	20%
Blue Cross	30%
Other Paying Patients	15%
Non-Paying Patients	10%

As we read the instructions, Medicare, and possibly Medicaid, patient days are subtracted from the total, leaving 55% of the total patient days. If Blue Cross pays "its proportionate share," it will pay 30/55ths. Therefore, the hospital must either charge the other paying patients 25/55ths of the bad debts, which is far more than their proportionate share, or will be unreimbursed for 10/55ths if they only charge the other paying patients their proportionate share.

5. It is noted that both the public defender, Mr. Martin L. Haines, Esq., and the Actuary of the Insurance Department, Mr. William White, stated in the record that charges to non-Blue Cross non-governmental patients customarily exceed Blue Cross reimbursement rates by about 20%. It is evident that these higher charges do not produce fat profits for the hospitals. On the contrary, they are direct and necessary consequence of the Blue Cross reimbursement formula. In light of the foregoing, we feel compelled to request that as part of the "record," that the Commissioner, pursuant to *N.J.S.A.* 26:2H-18, take a position as to whether or not *all costs* have been included in fixing or improving the rates.

6. For the purpose of establishing a clear "record," we further request that the Commissioner, pursuant to *N.J.S.A.* 26:2H-18, advise us as to whether or not such items as the training of personnel, research and depreciation, as well as other "hidden costs" incurred by such hospitals are included as part of the total cost for the fixing of rates to be paid by Blue Cross.

7. We find it necessary to object to the form of the "EXPANSION OF THE RECORD ON REMAND," inasmuch as we feel that the aforementioned "record" does not comply with the directives of this Court in that said "record" does not contain findings of fact or determinations of law as made by the Commissioner.

8. For purposes of this motion, I, as attorney for the plaintiffs, further incorporate by reference my prior Affidavit in support of the previous motion to comply with the Order of the Court.

Respectfully submitted,

KRIEGER & CHODASH

By: /s/ Harold Krieger
HAROLD KRIEGER

NOTARIZED

APPELLATE DECISION IN BORLAND, et al. v. BAYONNE HOSPITAL, et al

Argued June 3, 1975—Decided July 3, 1975

Before Judges Matthews, Fritz and Botter.

On appeal from the Superior Court, Chancery Divsion, Hudson County.

Mr. Harold Krieger argued the cause for appellants (Messrs. Krieger & Chodash, attorneys; Mr. Frank L. Brunetti, on the brief).

Mr. Bruce D. Shoulson argued the cause on behalf of all respondent hospitals (Messrs. Lowenstein, Sandler, Brochin, Kohl & Fisher, attorneys for respondent Beth Israel Medical Center; Mr. Michael L. Rodburg, on the brief).

Mr. Omer F. Brown, II, Deputy Attorney General, argued the cause for respondent Commissioners of Insurance and Health (Mr. William F. Hyland, Attorney General, attorney; Mr. Stephen Skillman, Assistant Attorney General, of counsel).

PER CURIAM

We affirm substantially for the reasons expressed by Judge Fink in his opinion reported at 122 *N.J. Super.* 387 (Ch. Div. 1973).

APPELLATE DECISION IN BORLAND, et al v. RICHARD McDONOUGH, et al

Argued June 3, 1975—Decided July 3, 1975

Before Judges Matthews, Fritz and Botter.

On appeal from the Commissioners of Insurance and Health.

Mr. Harold Krieger argued the cause for appellants (Messrs. Krieger & Chodash, attorneys; Mr. David Feinsilver, on the brief).

Mr. Omer F. Brown, II, Deputy Attorney General, argued the cause for respondents (Mr. William F. Hyland, Attorney General, attorney; Mr. Stephen Skillman, Assistant Attorney General, of counsel).

PER CURIAM

This case is a companion to *Borland, et al. v. Bayonne Hospital, et al.*, 122 *N.J. Super.* 387 (Ch. Div. 1973), which we affirmed this date.

After the Chancery Division Judge granted summary judgment in favor of defendant hospitals in the companion case, the action remained pending against defendant commissioners. The commissioners then moved before the Chancery Division to transfer that action to this court since it then consisted of an appeal from an administrative decision of a State agency. See *R.* 2:2-3(a)(2). The motion was granted. Thereafter, we remanded the pending action to the commissioners for expansion of the record. The record, as expanded, has been returned and we proceed to a disposition of the merits.

Basically, plaintiffs complain that the differential in the rates paid by the Hospital Service Plan of New Jersey

(Blue Cross) to hospitals as per diem reimbursement are discriminatory against them because that rate is lower than the rate charged by the hospitals to non-Blue Cross subscribers. The same constitutional arguments advanced in *Borland, et al. v. Bayonne Hospital, et al.*, above, are advanced here. The arguments of discrimination involving the equal protection clause were rejected in the companion case by the Chancery Division Judge, and we affirmed that rejection. We see no reason to change our decision because of the arguments advanced here. [We are satisfied that there is a *failure* on the part of plaintiffs *to prove* that the *differential in rates* charged by the hospitals because of the action of the commissioners *constitutes* either a *deprivation of due process or equal protection.*]

Plaintiffs also contend that the statute relevant to the duties of the commissioners in approving reimbursement rates mandates that the hospitals be reimbursed so that they recoup their total costs. The statute in quesion, *N.J.S.A.* 26:2H-18, reads in perinent part:

> b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him. • • •
>
> d. • • • In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

We do not read the statute as requiring that the rates fixed reimburse the hospitals so that they recoup their total cost outlay; rather, the statute clearly requires only that the commissioners consider the total costs in determining the percentage of costs to be reimbursed. To hold otherwise would divest the commissioners completely of discretion and actually render unnecessary the approval proceedings

required by the Legislature under the statute, thus reducing the commissioners' duties to nothing more than a rubber stamp.

Plaintiffs next argue that the guidelines under which the commissioners are to determine the approved reimbursement rates are unduly vague. As noted, the statutes require that the commissioners approve reimbursement rates after considering the hospitals' total costs. The legislative scheme established obviously relies upon the commissioners' expertise and the proper use of discretion in a very complex area. Delineation of specific statutory guidelines would serve only to restrict the commissioners' exercise of discretion. The exercise of discretion by the commissioners, and the establishment of guidelines by them in carrying out the legislative mandate are subject to judicial review. See *N.J.S.A.* 26:2H-17.

Finally, plaintiffs argue the commissioners must hold hearings before setting reimbursement rates. We have so held recently in an unrelated case. *Monmouth Medical Center, et al. v. State of New Jersey, et al.*, Docket numbers A-2147-74 to A-2151-74, incl.

Affirmed.

A TRUE COPY

/s/ Elizabeth McLaughlin

REPORT OF HEARER; IN THE MATTER OF THE 1975 HOSPITAL RATE REVIEW PROGRAM GUIDE LINES PROMULGATED BY THE COMMISSIONERS OF HEALTH AND INSURANCE IN FEBRUARY, 1975

On June 11, 1975 a hearing was held before me as hearer duly appointed to take testimony and receive statements and exhibit with repect to the 1975 Hospital Rate Review Program Guidelines promulgated in February 1975 by the Commissioners of Health and Insurance.

The Appellate Division of the Superior Court had, in *Monmouth Medical Center v. State of New Jersey*, determined that the Guidelines were promulgated in violation of the Administrative Procedure Act (*N.J.S.A.* 52:14B-1 *et seq.*). It accordingly remanded the matter to the Commissioners to proceed forthwith to fix reimbursement rates under the Health Care Facilities Planning Act (*N.J.S.A.* 26:2H-1 *et seq.*), in accordance with law, the proceedings to be concluded on or before June 1, 1975. The court not only invalidated the Guidelines but also any action taken thereunder by the Commissioners, including but not limited to the establishment of the 1975 initial *per diem* reimbursement rates. It declined to fix the rates at which hospitals were to be reimbursed by hospital service corporations.

Thereafter the Commissioners, on May 5, 1975, jointly promulgated the same 1975 Guidelines, to be used for a period of 60 days for the purpose of fixing interim rates. They also gave notice of a hearing to be held on June 11, 1975 for the adoption of the Guidelines as a temporary rule. To justify their adoption of the Guidelines without a hearing, the Commissioners filed certificates of emergency, purportedly pursuant to the authority of *N.J.S.A.* 52:14B-4(c).

The *Monmouth Medical Center* plaintiffs thereupon filed a petition for a rehearing of their earlier applications for relief, alleging that the Commissioners had not complied in good faith with the court's earlier determination. The Appellate Division again invalidated the adoption of the Guidelines and directed that a hearing must be held, on short notice, to give interested parties an opportunity to be heard. It extended for a reasonable time the period previously fixed for establishing interim reimbursement rates.

An estimated 300 persons attended the hearing on June 11, 1975. Over 60 requested an opportunity to be heard. Many of them did not respond when their names were called, but some 36 made oral presentations. Anyone present was given a week to file a statement of views and such other materials as were relevant to the matter under consideration. Many such statements and a considerable volume of materials were thereafter submitted. What follows reflects a study of the voluminous record, which includes not only the transcript of the hearing testimony, but statements filed, supplemental exhibits in support of the views given by those who support or oppose the Guidelines, and the Appellate Division briefs filed in the *Monmouth Medical Center* case, *Beth Israel Hospital vs. Finley*, and *Borland vs. Bayonne Hospital*.

The background facts and developments leading to the promulgation of the Guidelines were provided in the presentation of the Commissioner of Insurance and that made by Miss Cathleen A. Maloney, Chief, Health Facilities Analysis, in the Department of Health. As explained in the presentation made on behalf of the Commissioner of Insurance by Dr. Eleanor J. Lewis, the Department's Director of Consumer Services, the year 1974 represented a transitional period for the State's responsibility in fixing reimbursement rates under the Health

Care Facilities Planning Act. It was represented that prior to that year the hospital rate-setting process could well be described as a "peer review" program administered by the hospital industry itself. Hospitals entered 1974 with the assumption that that program would be maintained. Budget forms had been sent to all New Jersey hospitals during the third quarter of 1973 with instructions that they be completed and returned to the Hospital Research and Educational Trust (HRET—essentially the New Jersey Hospital Association) by December 1973. The forms were analyzed by the HRET staff and subsequently reviewed by members of the Budget Review Committee, consisting of some 30 New Jersey citizens, half of them hospital administrators, a quarter hospital trustees and a quarter hospital physicians.

The Insurance Commissioner reviewed the first set of Budget Review recommendations in late January 1974, and those involving some 28 hospitals were routinely approved consistent with prior practice. The Insurance Commissioner went on to explain that late in February 1974 it had become apparent that the recommendations of the Budget Review Committee were resulting in increased expenditures of about 12% by Blue Cross and Medicaid, as compared with payment rates for 1973. The Economic Stabilization Program was then still in effect, with a stated objective of limiting annual hospital cost increases to 6%. The then Acting Commissioner of Health and the Insurance Commissioner accordingly withdrew approval of the Budget Review-recommended rates as of March 1, 1974, and instituted studies of alternate methods for rate-setting which would entail a considerably greater degree of State involvement.

The first step in that process was effected on May 1, 1974 when, in an explanatory letter to the hospitals, the

basic objectives underlying the change in method were defined. These were that (1) the system must produce reasonable payment rates, within the letter and spirit of the statute, within which hospitals might be expected to be able to operate without adversely affecting a high quality of patient care; (2) the system had to have sufficient flexibility and responsiveness to recognize and accommodate changing economic factors and exceptional conditions, in order to avoid undue financial hardship for any hospital or the hospital industry as a whole; (3) the system should preserve the concept of peer review and the product of the Budget Review process, to the extent that these were not in conflict with the State's obligation to control the over-all level of hospital costs; and finally, (4) the system should put both the hospitals and Blue Cross on notice as to the consequences, in connection with final payment rates, of significant departures from tentative payment rates that had been established.

In his statement the Insurance Commissioner explained that this system produced payment rates which, on the average, were about half a percent less than had been recommended under the traditional Budget Review process. Since the release of these rates coincided with the termination of the Economic Stabilization Program, the hospitals were notified that one or two steps would subsequently be necessary to reflect inflationary and other factors as they emerged during the balance of 1974.

The first of these steps was taken in September. It entailed three modifications: (1) a substitution of each hospital's actual 1973 costs for its projected costs in determining an allowable "base year" component; (2) a singling out of energy cost components so as to permit a pass-through of increased costs resulting from the energy crisis, at rates that were realistic, and (3) the introduction of an over-all 9% economic projection factor to replace the

7½% factor underlying the approach of the Economic Stabilization Program. The net effect, said the Insurance Commissioner, was to increase hospital payment rates by about 1.1% over the May 1974 formula rates.

The final step in the program, we are told, was completed in early April 1975. Preliminary work was begun in October 1974, jointly by the Departments of Insurance and Health and representatives of the New Jersey Hospital Association. The first step taken was a questionnaire to each hospital, mailed November 6, 1974, requesting information as to its emerging 1974 costs, patient days and salary increases not anticipated when the original budget was submitted. Based on the completed questionnaire, the original Budget Review Committee's recommendations were recast to reflect the recommendations it would have made had the Committee been aware of the hospital's actual (as opposed to anticipated) patient days and of the salary consequences flowing from the termination of the Economic Stabilization Program. The rates produced by this process, it is said, averaged 2.4% more than the original HRET Budget Review Committee's recommendations for 1974, and 14.9% higher than the corresponding 1973 Budget Review-based rates. The Insurance Commissioner represents that the average 1973 Budget Review-approved rate (the reasonable average cost for one hospital day of inpatient service in New Jersey) was $95.16; the 1974 HRET-recommended reasonable cost came to $106.80, and the corresponding rates, according to the Insurance Department formula, at which hospitals were paid for 1974 admissions was $109.34.

The Insurance Commissioner stated that it had been hoped to release the final payment rates during late December 1974, but this was delayed because certain unavoidable conflicts arose between the Insurance Department

rates and the 1975 rates being developed by the Health Commissioner. Since 1974 was regarded as a transitional year, the rating process had to be compatible with both the prior and subsequent processes. It was therefore not until the first week in April 1975, after substantially all of the initial 1975 payment rates had been determined and the various appeal processes developed by the Health Department, that a complete agreement could be reached on release of the final 1974 tentative payment rates.

Miss Maloney was employed by the Department of Health shortly after the adoption of the Health Care Facilities Planning Act in 1971, to assist in the development of a uniform reporting and accounting system and in the implementation of the rate-setting sections of the law, *N.J.S.A.* 26:2H-5(b) and 18. She stated that until 1974 there were no material regulations approved to implement a State regulatory system for either reporting or rate setting. Finally, in the spring of that year the Health Department decided to obtain the help of consultants. After open bidding, and with the advice of a committee the Commissioners had set up to help in deciding upon the bidder best able to accomplish the task, the consultant contract was awarded the firm of Haskins and Sells. Miss Maloney was designated Project Director.

One of the first suggestions made by that firm was that an advisory committee be established, made up of representatives of those concerned with health care: hospitals, the New Jersey Hospital Association (NJHA), physicians' organizations, Blue Cross, hospital labor unions, private insurance companies, the State Medicaid Program and the Departments of Health and Insurance. The Departments proceeded to set up an Advisory Task Force Committee and to hold meetings of interested parties in order to obtain industry advice and input in connection

with the proposed 1975 rate-setting system. Agenda were prepared for Committee meetings and memoranda mailed to its members following their sessions. I have examined the composition of the Advisory Task Force Committee, its agendas, and the meeting memoranda; this record attests to the representative character of the Committee and the breadth and depth of its discussions and determinations.

On September 17, 1974 the Commissioners of Health and Insurance sent a joint memorandum to the chief executive officers of all New Jersey hospitals "to let concerned hospital officials know as soon as possible, the plans of the responsible Departments of the State for hospital budget review and rate setting for 1975." The memorandum stated that the Departments would undertake determination and certification of rates for 1975 in accordance with the mandate contained in the Health Care Facilities Plannng Act, and to facilitate the transition to the new system the Departments would use data prepared by the chief executive officers on the 1975 HRET forms already mailed to them. These forms were to be filed with the Department of Health by November 30, 1974. Another joint memorandum was mailed on October 9, along with supplemental forms and instructions needed for a proper analysis of the 1975 budget submissions. The hospitals were informed that the Departments would expect to begin issuing initial rates for 1975 during February 1975.

The Advisory Task Force Committee early set up subcommittees to make specific studies of concepts and elements to be used in the new rate-setting system. These subcommittees were: Reasonableness Guidelines, Inflation, Classification Structures, and Incentives. I have examined the record of the work of these subcommittees as contained in the reports issued after their meetings and

find there was significant input from the various sectors of the health care industry.

The Departments also issued an "H & I Newsletter" so that all hospitals would be aware of the progress the Departments were making in setting up the 1975 system. The first was issued September 17, 1974 and was followed by six other "Newsletters" giving detailed information of developments.

The first draft of the Reasonableness Guidelines was reviewed at a joint meeting on January 27, 1975 of the Advisory Task Force and the subcommittee on Reasonableness. A copy of that draft had been sent to all members on January 10, accompanied by a comment sheet requesting written comments on the draft. The Department of Health received only four comments, and it would appear that the January 27 meeting elicited no strong exceptions to the proposals. The draft and comments have been made available to me. The draft did not include a quantification of the Guidelines, that section not yet having been made final.

The next step taken was in early February 1975 when the Commissioners notified the hospitals that there would be foura rea workshops at which the Guidelines would be explained to hospital representatives. The workshops appear to have been well attended, and efforts were made to clarify issues that were of concern to the hospitals.

As Miss Maloney explained, and as certain correspondence before me indicates, members of the Advisory Task Force Committee and subcommittees specifically asked the Commissioners to state that although they had participated in committee work and provided a certain input for the Committee's findings, it should be understood that they were not in total agreement with all items in the

Guidelines nor with the system as finally developed by staff. However, Miss Maloney stated that, as Project Director, she felt there were some items which, in her words, "had sufficient confirmation from the hospital industry." Quoting from her hearing presentation, these items were as follows—and in quoting them I must note that there were those at the hearing who took objection to some of them:

The General Approach:

Rate setting involves answering the questions as to the reasonableness of the proposed cost increases. This approach was taken to respond to the criticism of other states' regulatory bodies that established a base year without any analysis as to which hospitals were well run and low cost during the base year and which hospitals were inefficient and high cost. To set rates without establishing base year efficiency penalizes the well-run hospital while the inefficient thrives because of the surplus built-in from the use of a base with no cost constraints.

Cost Centers:

The Departments combined all reported cost centers into thirty-one different centers to achieve some uniformity as to the components of each cost center. HRET previously had neither defined the components nor classified costs to ensure uniformity in reporting.

The members agreed to these costs centers and to the three levels at which costs could be analyzed:

Level I--cost centers that are common to all hospitals.

Level II—costs incurred by physician coverage, physician salary fees, interns and residents.

Level III—costs that are either non-controllable by the hospital, immaterial as regards rate determination, or costs for which accepted common bases are not available for comparison.

Budget Groups:

The concept of Budget Groups was discussed with the Advisory Committee and the Reasonableness Guidelines Committee. There was general agreement that the grouping of budget expenses made good sense from an operational standpoint. The Budget Groups established by the State's system aligned themselves to those used by HRET-Budget Review.

Modified Per Diem	Group A
Physician Coverage and Education	Group B
Depreciation and Interest	Group C

Hospital Peer Groups:

When the State took over the regulatory system they could not retain "peer review." Therefore the system set up peer groups in order to give the hospitals the opportunity of being compared to hospitals they considered to be similar. Significant input was given by the Advisory Task Force to determine the criteria for peer groupings and the Departments responded to every proposed change. Hospitals who expressed difficulty with the group they were assigned to for peer comparisons were changed into the group that they felt were cost comparable in operations, complexity of services, size and location.

Inflation:

There was total agreement on this section as the actual rate of inflation will be adjusted at the end of the year. Hospitals and New Jersey Hospital Association members

worked closely with the Departments in designing the "market basket" concept for measurement of actual inflation during 1975.

Volume Variances:

Volume variances are a necessary part of the system since hospitals historically have not projected their patient day load with any great accuracy. Since payment rates are based upon patient days a poor projection of utilization results in a higher *per diem* at year's end when no variance to total budget dollars is built into the system in response to patient day decline.

All members agreed that there was no real way that the Committee could come to total agreement on volume variances, but they did agree with the concept that some expenses are fully variable, some fully fixed, and other semi-variable. Each member had a suggestion as to the percent of variability for volume but it was admitted that suggestions were more than likely subjective as they are influenced by the way member hospitals actually responded to problems of utilization. The majority of the members did agree with the variability factors as set down in the Guidelines as being as reasonable as any other that might be suggested. No one felt he could justify the use of other variability factors as being any more reasonable or valid.

Appeals:

Much of the time of the Advisory Task Force was spent on the discussion of the appeals mechanism. New Jersey Hospital Association did say that they did not like the proposed appeal mechanism, particularly the proposed public or impartial compositions of the Commissioners' Appeals Board.

The appeals process, as drafted by the Committee, was published in the February 6, 1975 issue of the *New Jersey Register*. Before adopting the appeals rules, the Commissioners incorporated suggestions submitted by NJHA as to the composition of the Commissioners' Appeal Board. An appeal mechanism has thus been part of the Guidelines from the start.

The Advisory Task Force Committee did not help formulate nor did it agree to the section of the Guidelines dealing with quantification. The Committee members were of the opinion that definition of the line above which costs were to be questioned was for determination by the Commissioners. The Committee viewed its role as purely advisory and left to the Commissioners the task of setting reasonable payment rates.

In her statement at the hearing, Miss Maloney said that when initial rates for 100 hospitals were issued in February 1975 they were, on the average, 8% above the operating budgets recommended for 1974 by the HRET-Budget Review, and 7% over the July payment rate issued by the Commissioner of Insurance that hospitals were receiving at that time. These initial rates were issued on the advice of the Advisory Task Force Committee members who felt it would help the hospitals' cash flow and at the same time give the Departments ample time to review hospital budgets in detail and revise the rates. Issuance of the 100 initial rates made available average *per diem* increases some three months before HRET would have completed its budget hearings for the hospitals in question.

The statement presented by Dr. Lewis at the hearing on behalf of the Insurance Commissioner, and the statement (with its extensive exhibits) presented by Miss Maloney of the Health Department provided the hearer with

the necessary backdrop leading from the passage of the Health Care Facilities Planning Act of 1971 to the promulgation of the Guidelines. Before proceeding to a discussion of those parts of the record addressed to the Guidelines proper, reference should be made to sections of the Act pertinent to the subject matter under consideration.

Section 1 of the Act (*N.J.S.A.* 26:2H-1) declared it to be the public policy of the State that

> • • • hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health.

The Department of Health is given "the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services."

Section 4 (*N.J.S.A.* 26:2H-4) establishes in the Department of Health a Health Care Administration Board consisting of 13 members, 11 to be appointed by the Governor with the advice and consent of the Senate, and representative of medical and health care facilities and services, labor, industry and the public at large, and 2—the Commissioners of Health and Insurance or their designated representatives—to be members *ex officio*.

Section 5(b)—*N.J.S.A.* 26:2H-5(b)—provides

> b. The Commissioner, with the approval of the board, sall adopt and amend rules and regulations in accordance with the Administrative Procedure Act P.L.1968,c.410(C.52:14B-1 et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the establishment of requirements

for a uniform State-wide system of reports and audit relating to the quality of health care provided, health care facility utilization and costs; (2) certification by the department of schedules of rates, payments, reimbursement, grants and other charges for health care services as provided in section 18; and (3) standards and procedures relating to the licensing of health care facilities and the institution of additional health care services.

Finally, Section 18(c) and (d)—*N.J.S.A.* 26:2H-18(c) and (d)—states that

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

The purpose of the scheduled hearing was to inquire as to whether the Guidelines meet the test of reasonableness. The hearing was not concerned with the constitutionality of the Health Care Facilities Planning Act or with the actual rates thus far fixed.

A number of those who appeared at the hearing spoke of the particular healt hcare facilities they represented—their uniqueness in light of location, the character of the area served, the services rendered, patient mix, the existence of special programs and their extent, intensity of service, complexity of cases handled, and the like. Either explicit or implicit in some of these comments was that the best system would be the one that formerly existed, namely, to consider budgets and fix rates on a hospital-by-hospital basis. [In my view this misses the entire *purpose of the Health Care Facilities Planning Act*, which is *to establish reasonable rates* in light of overall consideration and analysis of health care costs, derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health].

And here I find unacceptable the characterization attributed to the Guidelines as being conceptual or formulistic. The approach to any problem must begin with one or more concepts which are discussed, analyzed and sorted out as practical and relevant in light of the factual complex which the problem involves. This is precisely what took place in the development of the Guidelines, as shown by the background history traced by Dr. Lewis, speaking for the Commissioner of Insurance, and by Miss Maloney of the Department of Health. After the Act was adopted in 1971 there was what has been described as "peer review" in the rate-setting process. Then came a short period of HRET-Budget Review input. There followed the first steps in the development of what are now the Guidelines—the joint product of the Departments, their consultants and the Advisory Task Force Committee and its subcommittees. The hospital industry was accorded every opportunity for presenting its ideas and constructive criticisms. In the end there emerged the Guidelines under discussion.

I find no merit in the claim that the Guidelines are formulistic, if what is meant by that term is that they lay down a hard and fast pattern to be applied in an absolute fashion to the hospital industry of New Jersey. The facts belie the characterization, for it ignores the process that is available to every health care facility. The Guidelines and the rules concerning 1975 rate review give every hospital the opportunity of sitting down with a staff analyst to discuss and possibly adjust the initial rate set. If this is not satisfactory, there is available an administrative appeal, open to the public. And if the result achieved still remains unsatisfactory, the hospital may appeal matters of policy and unresolved matters to the Commissioners' Appeals Board. The same appeal procedure is available as to the final rate. (Here it is appropriate to correct the remark of one speaker, that the Appeals Board has not yet been established; the contrary is true and the Board is functioning.) In short, the Guidelines and rules provide a flexibility that assures health care facilities a thorough review and adjustment of initial and final rates.

There is no need to review the Guidelines in detail, for they have been available for some time and are familiar to all interested parties. As stated in the Introduction to the Guidelines, the development of reasonableness guidelines for the 1975 hospital rate review program has been guided by the following constraints:

> The use of the HRET forms, data elements and definitions supplemented by selected actual data for 1974;
>
> The terms of existing Blue Cross contracts with the hospitals;
>
> The need to establish promptly an initial inpatient per diem rate to be used by Blue Cross, Medicaid and Title V for hospital reimbursement during 1975, and
>
> The requirement to determine final 1975 inpatient per diem rates based upon actual 1975 data.

As the Introduction expressly notes, the Guidelines represent *general* instructions to guide the Health Department analysts in their review of hospital budget submissions and their determination of payment rates. The instructions are explicit and detailed to insure that all hospitals are uniformly and objectively reviewed.

The approach to determining the reasonableness of operating costs involves a multi-faceted analysis of the functions of a particular hospital within a group or groups of hospitals. This analysis comprises three essential elements which may, in summary, be described as (1) data definiton by cost centers, peer groups and units of service; (2) a method for measuring reasonableness by base period costs, cost increases and employee compensation levels, and finally, (3) the quantification of the Guidelines.

Each of these three essential elements is carefully explained in detail in the Guidelines so that not only the Department analysts but the health care facilities may clearly understand what is involved in the rate-setting process. As Kathrine G. Bauer, Research Associate at the Harvard Center for Community Health and Medical Care, who has for the past few years been studying the processes of hospital rate-setting in seven programs in various parts of the nation, stated, one must remember that there is no established wisdom in the area of hospital rate-setting. This is an extremely complex and delicate task. It is complex because the product to be priced is so difficult to define and its quality so difficult to measure,

and any comparison rate reviewers try to make must take into proper account the current diversity among hospitals. There is also the fact that each hospital organizes and manages its particular activites in its own way, including the keeping of its accounts. And, Dr. Bauer continued, rate-setting is a delicate task because there are almost no recognized performance standards for hospital care, so that rate reviewers are forced to make either implicit or explict value judgments in reaching decisions. Finally, said Dr. Bauer, we presently lack definitive experience, since almost all rate review programs in the country have been operating for less than five years. She made these points in order to urge that whatever program New Jersey adopts for 1975 must necessarily be approached in an experimental way, with mechanisms built in for on-going evaluation and improvement.

Dr. Bauer was of the opinion that the Guidelines program for rate-setting operates within the general framework of the Act and so has a great potential for reinforcing the planning powers of the Health Department. She to establish a fair review process in that a distinction has been made between controllable and uncontrollable types of hospital costs. And there is a distinction between fixed and variable costs, with an allowance for volume changes, although in this area the particular parameters selected might be refined. The peer groupings of hospitals for comparison purposes are considerably less crude than those employed by many other programs, including Medicare, although such grouping also requires refining. In her opinion the appeals process, described as a crucial element in any rate-setting program, seemed designed to resolve differences in a timely manner.

Dr. Bauer pointed out that the specific criticism she had of the program is that hospital reports submitted

cannot be expected to provide truly comparable data: lacking a uniform chart of accounts and uniform reporting conventions, a standard report form can only yield the illusion of uniform data. Here I should observe that in an attempt to arrive at inital rates for 1975, the Department of Health, with the approval of the hospitals, had to use the HRET forms, and this for the purpose of providing the hospitals with initial rates at as early as a date as possible, in aid of cash flow. In light of the 1975 experience and the observations made by those who appeared at the hearing, it is to be expected that the Department will undoubtedly refine the forms used by hospitals in reporting. As noted, 1974-1975 is patently a transitional period.

Lawrence Lewin, President of Lewin & Associates, Inc., of Washington, D.C., a management consulting firm in the health field, had reviewed seven rate review programs and was of the opinion that the Guidelines represented a reasoned approach to rate-setting. He spoke of the use of the median—a line separating 50% of hospitals above and 50% of hospitals below the cost line—as probably too tight. However, as he explained in a letter following the hearing, there exists an appeal process, which must be viewed as an integral part of the rate-setting process, and this effectively neutralizes use of the median as an absolute standard. The problems of the median, criticized by a number of speakers, was in his view an administrative issue determining the number and intensity of appeals, but not necessarily the final approved rate. In his opinion it would probably be administratively wiser to set the median at a higher level, at least during the first year, and he urged that a more liberal criterion be selected in the future. I am in agreement with that opinion, if only because it may decrease the number of Department challenges for hospitals above the median, with resultant

appeals that require considerable time before a revised rate is determined.

Charles Calligaris, a representative of the Health Studies Faculty of the Maxwell School in Public Administration at Syracuse University and experienced in hospital administration, particularly in the area of reimbursement, was impressed by the effort apparently expended in developing the Guidelines. He stated that the program of budget review is consistent with the recent position taken by the American College of Hospital Administrators and with proposals under consideration by the Hospital Association of New York State. The strength of the Guidelines, he said, was in the assurance that all hospitals were uniformly and objectively reviewed. He reviewed various aspects of the Guidelines and found them generally satisfactory. He especially noted the availability of the appeals mechanism as a corrective device. However, although he recognized the benefit of Equivalent Inpatient Days (EIPD) as an analytical tool, he seriously questioned the equalization of units of service for inpatient and outpatient care based on dollar-for-dollar value and believed that this would become a matter of contention. (A number of hearing presentations also criticized the EIPD factor). I would recommend that the EIPD factor be re-studied by the Department in the light of the hearing and hospital appeals. Mr. Callagaris was also critical of setting off increased productivity against increased intensity of service. In a memorandum received from the Department after the hearing the validity of this criticism was recognized, and it is anticipated that a necessary correction will be made.

I have also received a statement from Steven M. Weiner, Chairman of the Massachusetts Rate Setting Commission, a body responsible for establishing rates of payments to

providers under the Massachusetts Medicare Program, and which approves all contracts by hospitals and Blue Cross, including the initial and final rates of payment. He states that the Commission considers the Guidelines an extremely thoughtful approach to the complex and difficult problem of utilizing hospital cost control. In its view the method properly balances the need of assuring public accountability for the use of funds generated from the public, and the issues of hospital financial viability and guarantee of access to hospital care. The Guidelines encompass the major control issues which must be included in any system for effective hospital cost control. The Massachusetts Commission believes that the Guidelines present an excellent base from which, as a result of experience, further refinements will flow. It views the use of the median as a challenge point for unit cost of service as reasonable for the first year. The approach taken with regard to volume variances was appropriate: the classification of 0%, 50% and 100% variables seemed reasonable, and experience would allow further refinement. Mr. Weiner said that the use of EIPDs seems to be required for certain services for which there are no existing measures, and their use appears reasonable.

Edward Karnasewicz, Deputy Director of the Connecticut Commission on Hospital and Health Care, presented a statement for the record in which he said that the approach taken by New Jersey is, in general, similar to that adopted in Connecticut. He fully supported the principles for data definition, the methodology for measuring reasonableness and the quantification pattern set out in the Guidelines. The peer groupings, he said, are an excellent concept; since there are basic similarities between certain kinds of hospitals, it is entirely appropriate to group them. The analysis of base period costs is a good approach. As for EIPD, it would be preferable to

use paid hours as a basis, for it is easier to understand. The use of volume variances is important, and the 0%, 50% and 100% is a reasonable place to start and presumably will be adjusted as experience is gained. The use of 12% as an inflation factor for supplies was generous.

Repeatedly stated in the hearing presentations was that the time lag involved in setting the initial rates and then revised initial rates (after staff adjustments and/or appeals) resulted in financial problems for the hospitals. The initial rates were made available by March 1975, earlier than under HRET-Budget Review system. As of June 16, 52 hospitals had been through the first steps of the appeals process: 30 had administrative appeals hearings and 22 accepted their rates after an office conference. The Department had to reschedule 26 appeals at the hospitals' request. Revised rates were issued in 33 cases. An appeal to the Commissioners' Appeals Board was filed by 2 hospitals. It is expected that all rate adjustments will have been made by August.

The time lag is undoubtedly due to the novelty of the system. The proposed timetable for 1976 is that budgets will be reviewed between September 1 and December 1, the initial rates issued before February 1, and that adjustments and appeals involving the initial rates completed by March 1. Whatever financial problems have been experienced by some hospitals in this transitional year of 1975 will, it is hoped, not be encountered in the 1976 year.

Donald Kane, of Arthur Anderson & Co., prepared a study at the request of the New Jersey Hospital Association. He made the point (as did others) that hospital trustees act in the public interest and their judgment as to cost should not be impaired. The fallacy here is that the Act delegates to the Commissioners of Health and

Insurance the responsibility for setting rates, and their judgment, reasonably exercised, must prevail.

Mr. Kane expressed the view that the Commissioners, in setting the rate for a particular hospital, act on the basis of assumed facts, average facts and facts developed by others, and this places everyone, including the hospitals, the public and health service corporations in a "tailspin." In his view, the Commissioners must "stick to the economic facts of the particular institution." His criticism is inaccurate. Facts are not assumed, facts are not averaged, as the record fully establishes.

Some of Mr. Kane's testimony was addressed to the New Jersey statute and the current Blue Cross contract with hospitals, rather than to the Guidelines. The statute was not the subject of the hearing. The Blue Cross contract specifies the costs and services it will cover, and has been in effect since 1971. The Commissioners elected to abide by it in reviewing rates, so that only those cost items specified in the contract as reimbursable by Blue Cross were included in setting the 1975 rates. (A similar constraint exists with respect to Medicare aid: federal legislation (*P.L.* 92-603) limits Medicare reimbursements to the amounts that would be determined using Medicare costing principles.) The fact remains that Blue Cross agreed to pay for those who are its subscribers, and no one else. Bad debts and indigent patient costs are excluded under the Blue Cross contract.

There is a further constraint. As stated, the Commissioners were asked to use existing HRET forms and instructions for 1975 rate review. Those forms lack uniform definitions, so that apparently high costs could result from differences in reporting among hospitals. They are also inadequate as regards legally approved or mandated changes, such as the cost impact of Certificate of

Need approved programs. Further, there is an inability to separate direct costs of ancillary and general service functions between inpatients and outpatients. In additions, case mix data are not readily determinable, and this mix of patients varies considerably among hospitals. It was therefore apparent from the outset that reasonable and equivalent rates could not be established entirely from data provided in the forms. Accordingly, initial thinking in developing the Guidelines was to establish criteria which Department analysts would apply and that would discuss at budget review meetings with hospital representatives. These conferences with staff, as well as the appeals process, would soon develop factors that ought to be and indeed are being considered in revising initial rates.

It merits repeating that at a meeting on February 17, 1975 hospital representatives requested that initial rates be issued as quickly as possible in order to improve cash flows. It was suggested that budgetary costs which could be accepted without question be identified and incorporated in the initial rates pending resolution of questioned items. The Commissioners accommodated this request. The record establishes that staff conferences and appeals have resulted in numerous adjustments to the initial rates —a process which undoubtedly will produce like results in the remaining budgets now in the course of re-examination.

In his memorandum expanding upon his summary testimony at the hearing, Mr. Kane projects what he terms "fallacies" in the Guidelines. First, he states that the Guidelines would result in usurping the responsibilities of hospital boards of trustees. I have already commented upon this contention: the Act controls.

Next, he claims that the Guidelines would force operating losses upon health care institutions in failing to recognize the "total costs" provision in *N.J.S.A.* 26:2H-18(d) —costs of necessary patient services would not be recovered in the established rates. By way of example he cites costs in excess of the median for various units of patients' services, and costs incurred during the period the rates are in effect and which were not incurred in the historical base period. What is overlooked is that the statute does not require that the rates fixed shall reimburse hospitals so that they recoup their total outlay; the statute requires no more than that the Commissioners *consider* total costs in determining just what is to be reimbursed. As the Appellate Division said in *Borland vs. McDonough*, Docket A-561-73, decided on the date of this report, "To hold otherwise would divest the Commissioners completely of discretion and actually render unnecessary the approval proceedings required by the Legislature under the statute, thus reducing the Commissioners' duties to nothing more than a rubber stamp." Mr. Kane's claim also ignores the revision of rates made possible after informal conferences with staff analysts and resort to the appeals process. In further support of his contention he cites the fact that bad debts and the cost of charity care are not recognized. They are not because, as just pointed out, they are not included in the Blue Cross contract.

Mr. Kane argues that the Guidelines would jeopardize future ability to serve patients by reason of their failure to recognize the need of hospitals to have a net income. Such net income, he says, would provide adequate working capital needs and adequate coverage of debt interest; it would avoid forced losses, off-set lags in obtaining a revised rate, protect the financial viability of institutions against inflation of costs and provide them with financial

stability. The short answer to all this is that net income is not within the purview of the rate-setting provisions of the Act.

Another of the "fallacies" is addressed to the use of the median. At this point it should be emphasized that the median is not an average of the costs of hospitals in the same group; it is a midpoint cost, as heretofore explained. The criticism of the median by Mr. Kane (and others who spoke) totally ignores the availability of the appeals process which, as stated, has already resulted in an appreciable number of revised initial rates.

Mr. Kane states that the Guidelines set out aribtrary rules and techniques which would defeat the objectives of the Act and be counter-productive in relation to the public interest. Here he points out that in determining hospital departmental costs there cannot be a realistic comparison among institutions. That argument has been mentioned heretofore. Admittedly, hospitals vary in many respects, but data definition (costs centers, peer groupings and units of service) provide a working basis for comparison. In any event, this criticism, like many others, ignores the appeals process. Under this same heading Mr. Kane states that the 12%, 17% and 20% inflation factors for supplies, employees and physicians, respectively, have no basis in fact. As a matter of record, these percentages were adopted after a careful consideration of many elements, including cost of living indices, national and state statistics, and other factors relating to inflation. The percentages are adjustable where a hospital presents persuasive facts to the analyst or on appeal.

An additional argument under the "fallacies" section of the Kane memorandum is that the Guidelines would compel hospitals to reduce the type, scope or quality of patient service, or result in increased rates for self-pay

and commercially insured patients. The fact remains that the Act deals exclusively with what Blue Cross should pay the hospital under its contract, for medical care given to its subscribers. It does not necessarily follow, that a hospital would reduce the level of patient care, and if it is forced to charge increased rates to non-Blue Cross patients, this would not make the Guidelines unreasonable. *Borland vs. Bayonne Hospital*, 122 *N.J. Super.* 387 (Ch. Div. 1973), held that the fact that such patients must pay a higher rate for services identical with those rendered Blue Cross subscribers does not deprive the former of due process or the equal protection of the laws. *Borland* was this day (July 3, 1975) affirmed on the opinion below.

Another "fallacies" argument, expanding upon one noted above, is that the statistical comparison of costs among health care institutions is unreasonable and contrary to the purposes of the Act because it assumes that institutions are so similar as to be identical; and such comparison does not recognize cost differences resulting from variations between hospital programs and services, and does nothing to relate costs to services offered. The Guidelines do not assume that hospitals are so similar as to be identical; they do recognize cost differences between and among hospitals, and the statistical comparisons represent as reasonable an approach to relating costs to services offered as is presently possible. The Guidelines are instinct with a determined effort to make cost comparisons meaningful and reasonable. This report has already referred to the relative difficulty of such comparisons, stemming in the main from the reporting system that had to be resorted to in connection with the 1975 rate-setting process.

A final "fallacy" projected by Mr. Kane is that the provision in the Guidelines for the issuance of the final rate

and appeals therefrom is grossly inadequate in that it is self-serving for the regulators. I find no proven inadequacies. The self-serving charge is directed to section 10 of the appeals rules which states that the final rate shall be determined retrospectively following adjustment of costs included in the original rate, after comparison with the certified actual costs for the budget year. Specifically, Mr. Kane points to the provision that adjustments shall be made for (among other things) such items "as may, in the judgment of the Department, be appropriate." This last, it is said, represents a "one-way street for the regulatory agency's own needs and purposes only." The argument so made assumes a degree of arbitrariness that any responsible administrative agency would avoid, at peril of reversal by the courts on appeal. Final rates have not, of course, yet been determined for 1975, and to assume that the Department of Health will not consider such other items presented by a hospital as could persuasively influence it to adjust the rate is to engage in surmise.

Mr. Kane's memorandum also includes a section on "technical errors" in the Guidelines. I shall briefly deal with some of them:

(1) It is asserted that the Guidelines assume that costs related to increased intensity will be off-set by productivity increases, and this is invalid. The Department acknowledges the error and will correct it.

(2) It is erroneously assumed that personnel cut-backs result in saving the total salary and the fringe benefit costs of positions eliminated. The Department recognizes that employment benefits are legally mandated. Adjustments would be included in the final rate calculation.

(3) The assumption that disallowed personnel hours can be eliminated by June 30, 1975 is unreasonable. The

Department states that where costs questioned in the initial rate calculation result in personnel reductions having to be made after administrative appeals, adjustments are made based on the individual hospital's situation.

(4) The assumptions as to variability of costs are unrealistic, arbitrary and unreasonable. This fails to recognize that the variability factors serve merely as guides; they cannot be defined nor are they applied precisely. The testimony of Mr. Lewin and F. Bernard Forand, Special Assistant to the Rhode Island State Budget Director, was that the variability factors are, as the Guidelines state, within the discreet ranges normally incurred in budgetary control systems. There has been no contradition of Miss Maloney's statement that no one, in the discussions that led to the Guidelines, "felt he could justify the use of other variability factors as being any more reasonable or valid."

(5) The units of service established to compute unit costs in each cost center are frequently not related to the proper unit of patient services. The Department agrees that this is so with respect to indirect costs that may be allocated to outpatients, and this can readily be corrected if properly presented to the Department analyst or on appeal by the affected hospital.

(6) The rate review schedules cause outpatient costs to be eliminated twice in arriving at the inpatient *per diem* rate. The Department asserts that Mr. Kane's statement regarding double elimination of emergency room, clinic and private ambulatory departments is not correct. Should the matter be otherwise, it should immediately be looked into. It goes without saying that any double elimination in arriving at an allowable *per diem* rate should be corrected.

(7) Base year cost are not properly adjusted to reflect a future year's cost for new programs or other changes in service. As regards 1975, I have been assured that this—as well as other technical matters referred to by Mr. Kane—is being dealt with in the course of the administrative appeals process. (See, for example, the testimony of James Hull, Health Department rate analyst.)

(8) The units of service established by the Guidelines to measure volume of activity and to project the effect of volume changes on variable costs are frequently not proper because not directly related to the true underlying levels of service which might affect costs. As an example, Mr. Kane cites the unit of measure for operating and recovery rooms is total acute admissions; a more appropriate unit, he feels, would be some direct measure of usage, such as quarter-hours or minutes of use. The Department points out that unless a hospital's patient mix changes dramatically in the course of a year, total acute admissions is an appropriate indicator of volume changes in the operating room. For the hospital whose patient mix does change, with a resulting impact on the operating and recovery rooms, such changes, where significant, can be dealt with when final rates are approved. The same would be true of Mr. Kane's observations regarding anesthesiology and inhalation therapy. If a case can be made out for volume changes in the hospital pharmacy so that costs are measured by patient days, this, too, can be corrected. The same observation may be made with regard to medical records work, now measured by the number of admissions.

(9) The rate review schedule designed to calculate the allowable salary rate increase fails to recognize changes in employee mix. Further, since new employees would normally be hired at the starting rather than the average

salary rate, the disallowed hours should be costed at the hospital department's budgeted average starting rate. The Department represents that where an employee mix changes to the detriment of a hospital, a correction is identified during the appeal process.

In summary, whatever technical differences flow from the Guidelines can be adjusted upon a proper case being made out by the hospital. In any event, the observations made at the hearing will serve as a basis for further refinement of the Guidelines by the Commissioners in connection with the 1976 rate-setting procedures. Such technicalities do not significantly affect the over-all validity of the Guidelines set down for 1975.

Some of the presentations at the hearing and in statements filed with me refer to items like debt service and depreciation not being adequately reflected in the setting of rates. The record is to the contrary: debt service and depreciation are factors given due weight in the fixing of rates. If, by chance, either of these factors has not been given proper consideration, the matter can be corrected after consultation with the analyst or on appeal, so that the revised initial rate, or at least the final rate, will include these items.

Some of those who appeared claimed that the Commissioners were disallowing expenses growing out of the grant of Certificates of Need, and that in setting rates the Commissioners were reviewing or re-evaluating programs they had previously approved. This, it was asserted, invades the prerogative of hospital trustees in fixing the level and quality of medical services after such services had been authorized by the Certificates of Need. Certificate of Need programs must, of course, find their reflection in the initial rate, revised rate or, at the latest, in the

final rate. The Department is aware that this is so and makes due allowance for such programs.

The New Jersey Hospital Association has filed a position paper addressed to the Guidelines. The position paper first states what is obviously true, namely, that any regulations adopted by the Commissioners to implement their statutory duty under *N.J.S.* 26:2H-18(d) must carry out the stated policy of the Health Care Facilities Planning Act, namely, approval of reasonable rates compatible with highest quality health care services.

NJHA, in Point 1 of its paper, attacks the median concept, stating that it subjects costs over the median to automatic challenge and disallowance, and disregards the decision of the hospital board that a certain level of staffing is necessary to provide the quality of care mandated by the hospital's charter and trustees. The result, it is said, effectively lowers the quality of care being offered by the top half of the hospitals by disallowing costs associated with such care. I find that such a standard of disallowance is also used by the Federal Government: a hospital is refused payment to the extent that a proposed cost falls above a certain percentile for all hospitals in its classification. (See notice by the U.S. Department of Health, Education and Welfare, issued on May 30, 1975 and appearing in the *Federal Register*.)

The Guidelines do not subject hospital costs over the median to "automatic challenge and disallowance." The Guidelines are clear that once the initial rate is established, a health care facility may file an appeal; section 8 of the proposed rules concerning 1975 hospital rate review directs that after a public hearing, "The agency chief shall render decisions in matters of apparent inequities where facts can be determined readily, and on issues peculiar to one institution . . ." The use of the

median as a screening device was, as earlier mentioned, supported by experts in the medical care rate-setting field.

The position paper also asserts that the Commissioners "have applied a formula approach [that] does not consider the unique characteristics of each health care facility," resulting in an unreasonable reduction in reimbursement rates which has no relationship to the scope, level or quality of care being rendered by the particular health care facility. Here, again, there is little appreciation of the salutary corrective process available through informal discussions with the Department analysts and through the appeals process.

The observation made in the first part of the position paper that the Guidelines do not allow a hospital to generate net income in order to provide for its capital needs, cover short and long-term debt and, in general, protect its financial viability and stability, has been the subject of my prior observation on that matter.

Point 2 of the NJHA position paper discusses services provided by a health care institution pursuant to a Certificate of Need and contends that any attempt, in the rate review process, to implicitly or explicitly reduce the level of service being offered, is contrary to the Act. To state NJHA's position fully, it maintains that once a Certificate of Need has been granted, the health care facility may implement the approved program. The Guidelines, it is said, would effectively provide for a re-review of such programs by disallowing reimbursement for annual costs approved by the Certificate of Need in 1974 or approved prior to that time but instituted in 1974. I have already addressed myself to this argument.

Point 3 of the position paper argues that the Guidelines must comply with substantive due process; there must be no unlawful interference with the operation of a health

care facility by establishing a reimbursement rate which fails to compensate it in a reasonable manner for costs incurred in health care delivery. It is contended that the Commissioners must, in adopting a regulatory scheme, not substitute their judgment for that of the management (the board of trustees) of the institution. The argument so made centers upon the median concept and the allegedly arbitrary wage rate increase percentages. I do not find this claim valid. The Guidelines provide in detail for as reasonable a reimbursement as can be derived from the cost figures submitted by the respective hospitals, considered in light of the data definitions, the method for determining reasonableness and the quantification provisions of the Guidelines already referred to.

This section of the position paper also argues that Blue Cross patients should be made to pay their fair share of total costs, and this is not accomplished because of the elimination from the Blue Cross rate of the cost of bad debts and charity cases. I have earlier dealt with this precise argument, and the *Borland* case, cited by NJHA, has disposed of the constitutional issue that non-Blue Cross patients are unfairly charged a different rate from those insured by Blue Cross. In any event, the due process and equal protection of the laws argument is for the courts, and not for this hearer to determine.

While Point 3 deals with substantive due process, Point 4 deals with the question of procedural due process. It is argued that the adjudication of disputed facts is different from and may not mask as rule-making. Examples given of the adjudication of disputed facts are the classification of hospitals, the use of equivalent units, the classification of costs (variable, semi-variable and fixed) and the 12%, 17% and 20% inflation figures. It is urged by NJHA that

> In passing upon the reasonableness of the reimbursement rate, the uniqueness, geography, individuality, service area, labor market, patient mix, size, educational programs, general industry standards and inflation are to be considered. Further, the reimbursement rate should be one which assures that the health care facility recovers the total cost reasonably and efficiently incurred in providing health care services. Therefore the reimbursement rate should include the following elements:
>
> 1. Current operating needs such as the direct patient care, operating expenses, education, research, charitable allowances and depreciation;
>
> 2. Plant capital needs such as preservation and replacement of existing facilities, acquisition of new technology, and statutorily approved expansion;
>
> 3. Working capital and operating cash needs;
>
> 4. The provision of a reasonable profit or net income.
>
> Items 2, 3 and 4, as heretofore noted, are not valid considerations in the setting of rates under the Act; the remainder of the recommendation involves elements already considered by the Commissioners.

The suggestion that provision should be made for a hearing at which a hospital is afforded the opportunity to appear and present evidence and argument on contested issue has merit. My understanding is that the public hearing afforded a hospital on administrative appeal and on appeal to the Commissioners' Appeals Board gives hospitals this very opportunity. My suggestion is that the proceedings on formal appeal be recorded, if that procedure is not now followed. There is no need evident for

creating such a record at the informal conference with the Department analyst; indeed, NJSA does not consider a formal record necessary.

As for the time schedule for presenting proposed budgets, processing them, supplying the health care facility with written comments concerning its proposed budget and requested reimbursement rate, the informal meeting with the analyst, the issuance of the initial rate and the holding of any subsequent appeal—such matters are addressed to a schedule which the Commissioners intend to follow after the present transitional period.

The section of NJHA's position paper entitled "Disallowances resulting from the proposed regulation should not apply retroactively" is not persuasive. The initial rate fixed by the Commissioners, and adjustments to that rate, are applied back to the beginning of the fiscal year, January 1, and Blue Cross is notified to pay the new rate as if it had been applicable since that date. Hospitals should realize that their cost figure is subject to review, and if that review results in disallowance of any item or items so as to reduce the proposed rate, it should in strict logic be retroactive to January 1.

Whatever comments were made at the hearing with respect to improvements in the Health Care Facilities Planning Act are properly addressed to the Legislature, as are those dealing with the statute relating to Blue Cross contracts, *N.J.S.A.* 17:48-7 and 8. Arguments as to constitutionality, on due process and equal protection grounds, must be resolved by the courts.

Considering that 1975 is a year of transition, that the Commissioners were obliged to use the HRET budget forms in order to accommodate the hospitals' desire for an early setting of initial rates in order to help their cash

flow, and that there exists a practical procedure for adjusting rates by informal conferences and, if necessary, by appeals, I find that the Guidelines, considered in their entirety, fairly meet the statutory public policy of reasonableness in setting rates that will enable hospitals to provide health care services of highest quality and of a demonstrated need, efficiently provided and properly utilized at reasonable cost. A thorough review of the presentations made at and after the hearing, including the exhibits, provides adequate support for this conclusion.

The hearing has served the good purpose of providing an airing of criticisms addressed to the proposed Guidelines. I am confident that some of them will provide the Commissioners with helpful suggestions for refinements and technical improvements.

/s/ Sidney Goldmann
SIDNEY GOLDMANN, Hearer

DATED: July 3, 1975.

AFFIDAVIT OF J. AUSTIN WHITE, AS FILED IN THE CASE OF BETH ISRAEL HOSPITAL, et al v. JOANNE E. FINLEY, et al, DOCKET NO. A-2039-74, IN WHICH SOME OF THE DEFENDANTS HEREIN WERE PLAINTIFFS

STATE OF NEW JERSEY)
) SS.:
COUNTY OF MERCER)

I, J. AUSTIN WHITE, of full age and being duly sworn according to law, upon my oath depose and say:

1. I am the Administrator of Hamilton Hospital which is located in the Township of Hamilton, County of Mercer and State of New Jersey.

2. Hamilton Hospital was founded in 1941 in Trenton, New Jersey. On November 15, 1971, the hospital moved to a new 113 bed facility in Hamilton Township. The State Department of Health issued a new license to the hospital and the Hospital Service Plan of N.J. required the hospital to enter into a new provider contract. The debt at time of opening was $4,000,000 F.H.A. mortgage and a $600,000 demand note secured by our pledges receivable.

Under the new Service Plan contract, the hospital was forced to accept a negotiated rate. This negotiated reimbursement rate did not provide for adequate depreciation and debt service. Funding of depreciation was required under our F.H.A. mortgage agreement.

In 1972 with an 80.4% occupancy, our certified cost was $98.44. The negotiated rate, based on the weighted average of four area hospitals, was $86.45 or $12.00 per day under our actual certified cost. In 1973, the hospital's

certified cost was $98.72 and the negotiated rate was $96.60 or $2.12 under the certified cost. This resulted in a Blue Cross deficit for 1972 and 1973 of approximately $246,750.

Seventy-five percent of the hospital's patients were covered by the Hospital Service Plan of N.J., Medicare and Medicaid contracts that normally provide cost recovery or charges, whichever is less. Another 20% paid charges and 5% were charity or non-collectibles.

The hospital has no endowment income or funds. The Blue Cross deficit had to be subsidized by the small balance of our patients who pay charges.

The 1974 operating budget was prepared under Phase III Rules and in anticipation of Phase IV of the Economic Stabilization Act. The subsequent removal of controls, the accelerated inflation rate, and the formulistic approach to hospital reimbursement has caused a major cash flow problem for Hamilton Hospital.

In March New Jersey hospitals were granted a 5% temporary increase on the 1973 per diem rate effective January 1, 1974. In the case of Hamilton Hospital, the increase was calculated on the 1973 negotiated rate of $96.60 rather than the anticipated certified cost of $98.77. This resulted in a temporary rate of $101.50 although the budgeted cost under the Federal economic controls was $110.18. Thus, a negative cash flow situation existed.

On August 28, 1974, Hamilton Hospital was granted a new tentative per diem rate of $107.10. This adjustment did not adequately take into account the inflation factor and thus, the negative cash flow position persisted.

The next and final adjustment was granted on September 16, 1974, as an energy adjustment of 3.3 cents per kilowatt hour and an economic projection factor increase

from 7½% to 9%. The tentative per diem thus became $110.40 and has so continued.

Our audited cost for 1974 is $123.78. It should be noted that in spite of the inflationary pressures created by sizable mid-year salary increases granted by neighboring hospitals, Hamilton stayed within its original payroll budget. The increases were in areas of food, power, medical, surgical and other supplies over which we had little control.

The lack of timeliness in the setting of reasonable reimbursement rates has created serious cash flow problems. This problem has been further aggravated by the hospitals' effort to reduce the patient length of stay.

Hamilton Hospital had an average length of stay of 8.9 days in 1972, 8.3 days in 1973 and 7.4 days in 1974 which is one-half a day under the budgeted length of stay for 1974. Although the hospital increased its admissions by 320 patients or 7½% over 1973, there was a net loss in patient days of 4.3%. The drop of 1,866 patient days under budget represented reduction of approximately 875 Blue Cross days or $96,000 at the interim approved rate of $110.40.

Although the patient days decreased, it did not have a comparable decrease in the ancillary departments. In fact, with the increase in admissions, most of the ancillary departments had an increase in productivity over budget for inpatients as follows:

	Budget	Actual
Radiology Procedures	9,150	10,309
Operations (2 rooms operating)	2,400	2,541
Laboratory Tests	65,800	65,172
EKG Examinations	3,520	4,184
Radioisotope Procedures	450	603

It is readily apparent that the intensity of care increased with the increase in admissions and the shortening of stay. The faster turnover of patients increased the need for cash.

The relatively small size of the hospital and the high fixed cost requires that the hospital function within very limited perimeters. A decrease of 11 patients represents 10% reduction in our inpatient income assuming 100% occupancy base.

Our daily cash needs are as follows:

Salaries & Wages	$ 7,400
Physician Fees	600
Supplies & Expenses	4,400
	$12,400
Debt Service	1,100
Funded Depreciation	500
Total Daily Cash Needs	$14,000
Source of Funds:	
Outpatient Provides	$ 2,500
Other non-patients	200
Inpatients have to provide (Average Daily Census 93.2 x $121.25)–	11,300
Total	$14,000

The daily cash loss on Blue Cross patients at an average daily census of 45 patients is $488.00 ($121.25 average daily per diem reimbursement need at a 93.2 daily census less $110.40 current reimbursement–$10.85 per patient x 45 patient days = $488.00 daily loss).

The high fixed costs and the sensitivity to census changes can be readily seen. The hospital survived a major census drop in November and December of 1974 by taking drastic short-term measures including reduction of all salaries and wages to approximately a 37½ hour level (a number of employees took time off without pay and vacan-

cies were left unfilled), by reducing inventories to an absolute minimal level, and by withholding payments to vendors in excess of 90 days. The latter resulted in the utility vendors threatening to cut service. Dietary vendors placed the hospital on C.O.D. and a major medical supplier added 1½% on all balances over 60 days.

Long-term measures to control cost include in-house management engineering, staffing levels for all departments with weekly staffing reports, and vacancies are being filled only where there would be a major impact on patient services.

Hamilton Hospital is due approximately $200,000 in retroactive adjustments for funds expended on behalf of Blue Cross patients treated at Hamilton Hospital and is in need of an interim adjustment of approximately $100,000 to provide the liquidity for prudent financial management of the hospital.

The hospital has absolutely no cash reserve and thus, depends solely on patient income to meet its operating expenses. Any downward change in patient admissions would create an immediate financial crises.

Further, due to the hospital's heavy indebtedness, its borrowing ability is extremely limited. We, therefore, must look to the timely recovery of funds due us under our contractural arrangement with the Hospital Service Plan of New Jersey.

Sworn to and Subscribed before me this 4th day of March, 1975.

/s/ J. Austin White
J. AUSTIN WHITE

/s/ Linda L. Applin
LINDA L. APPLIN
Notary Public of New Jersey
My Commission Expires: 2/8/79

LETTER OF DAVID FEINSILVER, ESQ. TO JUDGE MATTHEWS, FRITZ AND BOTTER RE: DECISION, BORLAND et al v. McDONOUGH, et al

July 9, 1975

Honorable Robert A. Matthews
United Professional Building
Union Avenue
Brielle, New Jersey 08730

Honorable John W. Fritz
West High Street
Somerville, New Jersey 08876

Honorable Theodore I. Botter
Court House
Hackensack, New Jersey 07601

Re: John Borland, Jr., et al. v. Richard McDonough, et al. Docket No. A-561-73

Dear Honorable Sirs:

Our office is in receipt of your decision dated July 3, 1975 in the above-captioned matter. After carefully reading said decision, we feel compelled to respectfully request that you indulge the plaintiffs with a clarification of the meaning and legal effect of the very last paragraph appearing on page four of said decision wherein you have acknowledged that hearings must be held prior to the setting of reimbursement rates. See also *Monmouth Medical Center, et al. v. State of New Jersey, et al.*, docket numbers A-2147-74 to A-2151-74, incl.

In our briefs and at oral argument, we strongly took the position that the Commissioners, in promulgating their rules and regulations and in setting the Blue Cross rates,

pursuant to their respective responsibilities under the provisions of *N.J.S.A.* 26:2H-18(c) and (d) and *N.J.S.A.* 52:14B-4(a) and otherwise failed to provide the plaintiffs, the hospitals, and all other affected parties the due process guarantees of notice and opportunity to be heard, thereby rendering all such rules, regulations, and especially rates, to be null, void and of no effect. Our arguments with respect to this issue were substantially ignored by the repondents.

After due consideration of your decision, it appears to the undersigned that the logical inference to be drawn from said paragraph is that since the rules, regulations, and rates were not properly established, that they must fall.

Whereas your opinion does not appear to provide a statement illuminating the legal effect of your conclusion in said paragraph, we would be most grateful if you could give us further guidance.

In the event that you would deem further oral argument on this issue to be more appropriate and/or meaningful, then, in that event, we most respectfully request that this matter be set down for a rehearing on said issue.

Respectfully yours,

KRIEGER & CHODASH

By: /s/ David Feinsilver
DAVID FEINSILVER

DF:sgd
cc: Omer F. Brown, II
Deputy Attorney General

Mrs. Elizabeth McLaughlin
Clerk of the Appellate Div.

LETTER OF HON. ROBERT A. MATTHEWS, P.J.A.D. TO DAVID FEINSILVER IN REPLY

July 11, 1975

David Feinsilver, Esq.
Messrs. Krieger & Chodash
921 Bergen Avenue
Jersey City, New Jersey 07306

Re: John Borland, Jr., et al. v. Richard McDonough, et al. A-561-73

Dear Mr. Feinsilver:

This is in response to your letter of July 9, 1975, concerning the above mentioned matter. It is not appropriate for us to take any further action on the basis of your letter.

Very truly yours,

/s/ Robert A. Matthews
ROBERT A. MATTHEWS
P.J.A.D.

RAM:bs
cc: Hon. John W. Fritz
Hon. Theodore I. Botter
Omer F. Brown, II, Deputy
Attorney General
Mrs. Elizabeth McLaughlin
Clerk, Appellate Division

NOTICE OF APPEAL TO SUPREME COURT
IN BORLAND, et al v.
BAYONNE HOSPITAL, et al

Notice is hereby given that plaintiff-appellants, John Borland, Jr., et al, appeal to the Supreme Court of New Jersey from the Final Judgment of the Appellate Division of the Superior Court (the judges sitting therein being Matthews, Fritz, and Botter), entered in favor of Defendants-Respondents on July 3, 1975.

KRIEGER & CHODASH
Attorneys for Appellants

By /s/ David Feinsilver
DAVID FEINSILVER

Dated: August 15, 1975

NOTICE OF APPEAL TO SUPREME COURT
IN BORLAND, et al v. RICHARD McDONOUGH, et al

Notice is hereby given that appellants, John Borland, Jr., et al, appeal to the Supreme Court of New Jersey from the Final Judgment of the Appellate Division of the Superior Court (the judges sitting therein being Matthews, Fritz, and Botter), entered in favor of Respondents on July 3, 1975.

KRIEGER & CHODASH
Attorneys for Appellants

By: /s/ David Feinsilver
DAVID FEINSILVER

Dated: August 15, 1975

PETITION FOR EXTENSION OF TIME TO FILE APPELLANTS' BRIEF IN BORLAND, et al v. BAYONNE HOSPITAL, et al

(Filed October 7, 1975)

TO: THE HONORABLE RICHARD J. HUGHES
Chief Justice of the Supreme Court of New Jersey:

The petition of the plaintiffs-appellants, John Borland, Jr., et al, respectfully shows that:

1. The plaintiffs-appellants filed a Notice of Appeal in this case on August 19, 1975.

2. On July 3, 1975, the Appellate Division of the Superior Court (The Honorable Judges Matthews, Fritz and Botter) entered Final Judgment in favor of Respondents.

3. The copies of the Briefs and Appendices of the plaintiffs-appellants should be served on or before October 3, 1975.

4. The plaintiffs-appellants desire permission for the extension of the time for the serving and filing of the copies of their Briefs and Appendices until the 3rd day of November, 1975.

5. No previous extension of time has been made in the appeal of this case.

6. The plaintiffs-appellants request the aforesaid extension of time as a result of extensive calendar and other commitments that would foreclose giving the complex and intricate issues of this matter the proper treatment. Plaintiffs-appellants submit that the prayed for extension would serve the best interests of justice as the matters raised in this action are of grave import to the populace of New Jersey and deserve to be presented to, and determined by, the court in such a way as to result in an adjudication on the merits.

WHEREFORE, the plaintiffs-appellants pray, for the reasons set forth herein, that this Court may grant an Order extending the time for the serving and filing of their Briefs and Appendices from the 3rd day of October, 1975 until the 3rd day of November, 1975.

Respectfully submitted,

KRIEGER & CHODASH
Attorneys for
Plaintiffs-Appellants

By: /s/ David Feinsilver
DAVID FEINSILVER

DATED: Sept. 22, 1975.

CERTIFICATION OF VERIFICATION

I, DAVID FEINSILVER, attorney for the above named plaintiffs-appellants do hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to punishment.

/s/ David Feinsilver
DAVID FEINSILVER
Attorney for
Plaintiffs-Appellants

DATED: Sept. 22, 1975.

CONSENT ORDER TO EXTEND TIME
(Filed October 7, 1975)

This matter having been brought to the attention of the Court by David Feinsilver, Esq., attorney for plaintiffs-appellants, on a verified petition praying for the extension of the time for the service of the copies of the Briefs and Appendices by the plaintiffs-appellants from the 3rd day of October, 1975 until the 3rd day of November, 1975, and the attorneys for defendants-respondents having duly consented to the entry of the Order,

It is therefore, on this 7th day of October , 1975,

ORDERED that the time within which the plaintiffs-appellants, John Borland, Jr., et al, shall serve and file their Briefs and Appendices on this appeal shall be and the same is hereby extended and enlarged from the 3rd day of October, 1975 until the 3rd day of November, 1975.

/s/ Richard J. Hughes
RICHARD J. HUGHES,
Chief Justice

By: /s/ Florence R. Peskoe

We hereby consent to the entry and form of the foregoing Order.

PITNEY, HARDIN & KIPP
Attorneys for
Respondent-Hospital Service
Plan of New Jersey

By: /s/ Clyde A. Szuch
CLYDE A. SZUCH

DATED: September 23, 1975.

LOWENSTEIN, SANDLER,
BROCHIN, KOHL & FISHER
Attorneys for
Respondent-Hospitals

By: /s/ Bruce D. Shoulson
BRUCE D. SHOULSON

DATED: , 1975.

PETITION FOR EXTENSION OF TIME TO FILE APPELLANTS' BRIEF IN BORLAND, et al v. RICHARD McDONOUGH, et al

(Filed October 7, 1975)

TO: THE HONORABLE RICHARD J. HUGHES
Chief Justice of the Supreme Court of New Jersey:

The petition of the plaintiffs-appellants, John Borland, Jr., et al, respectfully shows that:

1. The plaintiffs-appellants filed a Notice of Appeal in this case on August 19, 1975.

2. On July 3, 1975, the Appellate Division of the Superior Court (The Honorable Judges Matthews, Fritz and Botter) entered Final Judgment in favor of Respondents.

3. The copies of the Briefs and Appendices of the plaintiffs-appellants should be served on or before October 3, 1975.

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6. The plaintiffs-appellants request the aforesaid extension of time as a result of extensive calendar and other commitments that would foreclose giving the complex and intricate issues of this matter the proper treatment. Plaintiffs-appellants submit that the prayed for extension would serve the best interests of justice as the matters raised in this action are of grave import to the populace of New Jersey and deserve to be presented to, and determined by,

the court in such a way as to result in an adjudication on the merits.

WHEREFORE, the plaintiffs-appellants pray, for the reasons set forth herein, that this Court may grant an Order extending the time for the serving and filing of their Briefs and Appendices from the 3rd day of October, 1975 until the 3rd day of November, 1975.

Respectfully submitted,

KRIEGER & CHODASH
Attorneys for
Plaintiffs-Appellants

By: /s/ David Feinsilver
DAVID FEINSILVER

DATED: Sept 22, 1975.

CERTIFICATION OF VERIFICATION

I, DAVID FEINSILVER, attorney for the above named plaintiffs-appellants do hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are false, I am subject to punishment.

/s/ David Feinsilver
DAVID FEINSILVER
Attorney for Plaintiffs-Appellants

DATED: Sept 22, 1975.

CONSENT ORDER TO EXTEND TIME
(Filed October 7, 1975)

This matter having been brought to the attention of the Court by David Feinsilver, Esq., attorney for plaintiffs-appellants, on a verified petition praying for the extension of the time for the service of the copies of the Briefs and Appendices by the plaintiffs-appellants from the 3rd day of October, 1975 until the 3rd day of November, 1975, and the attorneys for defendants-respondents having duly consented to the entry of the Order,

It is therefore, on this 7th day of October, 1975,

ORDERED that the time within which the plaintiffs-appellants, John Borland, Jr., et al, shall serve and file their Briefs and Appendices on this appeal shall be and the same is hereby extended and enlarged from the 3rd day of October, 1975 until the 3rd day of November, 1975.

/s/ Richard J. Hughes
RICHARD J. HUGHES,
Chief Justice

By: /s/ Florence R. Peskoe

I hereby consent to the entry and form of the foregoing Order.

WILLIAM F. HYLAND
Attorney General of New Jersey
Attorney for Respondent
Commissioners

By: /s/ Herbert K. Glickman
HERBERT K. GLICKMAN
Deputy Attorney General

DATED: , 1975

Supreme Court of the United States

OCTOBER TERM, 1976
No. 76-1412

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

BRUCE D. SHOULSON,
Attorney for Defendant-Respondent, Hospitals (Other than Saddle Brook Hospital)
744 Broad Street,
Newark, New Jersey 07102

Of Counsel
LOWENSTEIN, SANDLER,
BROCHIN, KOHL & FISHER

On the Brief
BRUCE D. SHOULSON
R. BARRY STIGER

N.J. Appellate Printing Co., Inc., South Plainfield, New Jersey (201) 753-0200

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1977

No. 76-1412

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

Petitioners,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

Respondents.

Respondent hospitals pray that the Court deny the petition for a writ of certiorari to review the decision of the Supreme Court of New Jersey affirming the decisions of the Superior Court of New Jersey, Chancery Division and Appellate Division.

QUESTION PRESENTED

Does state action which permits the creation of non-profit, closely regulated hospital prepayment plans, and permits such plans to be charged less than other hospital

users for the same hospital services, all in order to encourage a broad based community health program, violate the Fourteenth Amendment to the United States Constitution?

STATEMENT OF THE CASE

By their petition for a writ of certiorari, petitioners challenge the favorable rate structure which exists under New Jersey law for nonprofit hospital service corporations, such as Hospital Service Plan of New Jersey ("Blue Cross"), as a means of encouraging the general public to purchase insurance for hospital care. The petition has been consolidated with a petition in a companion case brought by petitioners against the Commissioners of Insurance and Health of the State of New Jersey ("Commissioners") in which petitioners allege that the Commissioners have improperly discharged their statutory functions in establishing the Blue Cross reimbursement rates.

Respondent hospitals submit that on the basis of well-founded and long-standing decisions of this Court, *see, e.g. City of New Orleans v. Dukes*, – U.S. – (1976) 44 U.S.L.W. 5074 (U.S. June 22, 1976), none of the reasons advanced by petitioners raises any special and important issue which this Court, in the exercise of its sound judicial discretion, should review (S.Ct. *Rule* 19).

New Jersey Cost Reimbursement System:

A review of the applicable New Jersey statutory frame-work and administrative process is necessary to an analysis of petitioners' contentions.

In order to encourage broad segments of their populations to achieve security from medical indigency by budgeted prepayments, New Jersey and most other states

have adopted legislation authorizing the creation of tax-exempt hospital service corporations, the largest group of which is generally known as Blue Cross. Hospital Service Corporation Act, *N.J.R.S.* 17:48-1, *et seq.*; *see Associated Hospital Service, Inc. v. Milwaukee*, 13 Wis. 2d 447, 109 N.W. 2d 271, 88 A.L.R. 2d 1395 (1961). In New Jersey, Blue Cross contracts with group and individual subscribers to provide hospital services. Contracts with subscribers are subject to statutory regulation and the contracts and rates charged are subject to disapproval by the Commissioner of Insurance. *See N.J.R.S.* 17:48-6, 6.1-6.9, 8 and 9. Blue Cross also contracts with health care facilities such as respondent hospitals for the rendering of health care services to subscribers at per diem rates (reimbursement rates), unique to each such facility, which rates are approved as to reasonableness by the Commissioner of Insurance following certification made pursuant to section 18 of the Health Care Facilities Planning Act, *N.J.R.S.* 26:2H-1, *et seq*. The statutory and administrative framework for the determination of such reimbursement rates is at the crux of petitioners' allegations of unconstitutionality. But, as discussed in detail below, respondent hospitals are not in any way responsible for the challenged statutory and administrative framework.

N.J.R.S. 26:2H-18 provides in pertinent part as follows:

> "c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

> "d. Payment by hospital service corporations . . . for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility."

In practice, until 1975 the rate-making process involved the appointment of a Budget and Advisory Committee to which New Jersey hospitals, each October or November, submitted their proposed operating budgets for the coming calendar year on forms provided by the Commissioner of Insurance. The Committee was organized by an affiliate of the New Jersey Hospital Association to assist the Commissioners in evaluating budgets. The forms provided for the exclusion of certain costs based on policy decisions made by the Commissioner of Insurance.

Prior to 1975, the Advisory Committee recommended to the Commissioner of Insurance for his approval a tentative per diem reimbursement rate for the operating year for each hospital. The reimbursement rate is an all-inclusive one which, as part of the health care financing system envisioned by the statute, does not necessarily relate to utilization of particular hospital facilities or services. This is in contrast to the hospitals' established charges to the public which are based on actual utilization. Beginning with 1975, the Commissioner of Health instituted a new system which does away with the Budget and Advisory Committee and relies on strict budgetary controls as administered by the staff of the Department of Health. *See N.J.A.C.* 8:3-1, *et seq.*

Under both the systems in force prior to 1975 and thereafter, the reimbursement rates as finally determined by the Commissioners have not fully reimbursed contracting hospitals for all costs incurred. The deficiencies are due to the Commissioners' exclusion of certain costs as being unreasonably incurred or in categories not eligible for reimbursement. In addition, the losses resulting from care rendered to indigents are not considered in the rate calculation. As a result, in order to recover the costs and losses not otherwise reimbursed, New Jersey hospitals, such as the respondents in the instant case, are forced to charge those patients who are not participants in cost reimbursement programs, such as Blue Cross, Medicare and Medicaid, rates in excess of so-called cost. Private insurance carriers, welfare funds such as those administered by petitioner trustees and uninsured patients comprise the group required to pay the higher charges.

Proceedings Below:

Petitioners, Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO (hereinafter "Union") and Howard Marks, alleged to be a union member and eligible beneficiary of the Union Welfare Plan, originally instituted the within action against 22 New Jersey hospitals, the Commissioners of Health and Insurance, and Blue Cross. The petitioners sought injunctive relief and damages for alleged discrimination by respondent hospitals in charging petitioners at higher rates for hospital services than are permitted by the Commissioner of Insurance for reimbursement for similar services rendered to Blue Cross subscribers (P7a-13a).[1]

1. References in this brief to the petition will be indicated by a "P" followed by the page number, while references to petitioners' appendix will be indicated in the same manner but with an "a" following the page designation.

In separate counts of the Complaint which are only relevant to the petition in the companion case before this Court, petitioners alleged: (i) that the approval by the Commissioner of Insurance of the Blue Cross rate of reimbursement of respondent hospitals constituted a denial by the Commissioner of Insurance of petitioners' rights to equal protection of the laws and to due process of law in contravention of the provisions of the Fourteenth Amendment to the United States Constitution (P13a-14a); and (ii) that the Commissioners of Health and Insurance, respondents in the companion case, have acted illegally and in a discriminatory and unfair manner in their approval of the rate of reimbursement of respondent hospitals by failing to take into account all of the costs of the health care facilities as required by *N.J.R.S.* 26:2H-18(d) (P16a-17a).

Respondent hospitals moved in the trial court to dismiss the Complaint as it related to them, and specifically to dismiss the counts of the Complaint which alleged that their activities violated plaintiffs' rights under the Fourteenth Amendment. The motion to dismiss was based on the premise that so far as the respondent hospitals were concerned, the factual and legal basis of the case was completely contained in the Complaint, the Hospital Service Corporation Act, *supra*, and the Health Care Facilities Planning Act, *supra*. The hospitals conceded the existence of the differential but pointed to the fact that under the applicable statutes, the Commissioners had the authority to fix the Blue Cross reimbursement rate. Accordingly, the hospitals argued that if petitioners were prejudiced by the rates set by the Commissioners, they should pursue their remedy against the Commissioners and not against hospitals which had no control over the situation.

After reviewing the extensive briefs filed by the parties and considering their oral arguments, the trial court treated the hospitals' motion as a motion for summary judgment and ruled that as a matter of law neither Blue Cross nor the respondent hospitals control the Blue Cross reimbursement rate, since that function is vested by statute in the Commissioner of Insurance, subject to the approval of the Commissioner of Health (P37a). Accordingly, the trial court found there to be no issue of fact before it, and in the judgment of the Court, the issues presented by respondent hospitals' motion were legal in nature only. As to the omission of certain costs from the Blue Cross reimbursement formula, the trial court held that not to be an issue between petitioners and the hospitals and Blue Cross but rather an issue between petitioners and the Commissioners of Health and Insurance (P39a).

The Commissioners of Health and Insurance did not move to dismiss the Complaint as to them and the trial court ruled that the action was to proceed solely against the Commissioners on the issues relating to their enforcement of the applicable statutes. In fact, the Court noted in its opinion that the respondent hospitals had reserved for themselves the right to proceed against the Commissioners on the same issue raised by petitioners, namely, the Commissioners' failure to adhere to the statutory requirements and consider all costs in determining the applicable Blue Cross reimbursement rate (P39a).

As the basis for upholding the constitutionality of the legislative structure establishing hospital service corporations such as Blue Cross, and regulating their operations, the Court found the statutory pattern to bear a reasonable relationship to the permissible legislative objective of establishing a broad-based community health program (P42a).

On April 13, 1973 petitioners filed their Notice and Appeal from the decision of the trial court (P55a).

On July 3, 1975 the Superior Court of New Jersey, Appellate Division unanimously affirmed the entry of summary judgment in favor of respondent hospitals and Blue Cross. (P81a).

On August 15, 1975 petitioners filed a Notice of Appeal to the Supreme Court of New Jersey (P130a).

On January 13, 1977 the New Jersey Supreme Court unanimously affirmed the judgments of the Courts below (P18).

On April 13, 1977 petitioners applied to this Court for a writ of certiorari to the Supreme Court of New Jersey.

ARGUMENT

I. THE STATUTORY PROGRAM ENACTED AND ADMINISTERED TO SECURE BROAD COMMUNITY HEALTH INSURANCE COVERAGE AT MODERATE COST WHICH HAS THE EFFECT OF PERMITTING BLUE CROSS TO REIMBURSE PARTICIPATING HOSPITALS AT RATES WHICH ARE LOWER THAN PETITIONER — NONSUBSCRIBERS' RATES FOR THE SAME SERVICES DOES NOT VIOLATE THE FEDERAL CONSTITUTION.

In the various proceedings in this matter before the New Jersey courts, petitioners took the position that the statutory scheme which established Blue Cross and is the basis for the existing regulatory system itself violated the Federal Constitution (P40a). The constitutional issues raised by petitioners were extensively treated in the opinion of the trial judge (P32a, *et seq.*) which in turn was relied upon by the eight appellate judges who subsequently reviewed and unanimously affirmed the trial judge's decision in this case.

By contrast, in their petition to this Court, petitioners have seemingly altered their approach and now focus their argument on what they allege to be an unconstitutional *administration* of the statutory system. Petitioners allege that by permitting Blue Cross to pay for hospital services on a preferential basis, the Commissioners have created an improper classification of hospital payers. One class of such payers (*e.g.*, Blue Cross) is not required to carry the burden of certain hospital costs, while another class (*e.g.*, petitioners) is forced to pay these costs, and thus "de facto subsidize" the first class (P10). According

to petitioners, there is no basis in law for this unequal treatment.[2]

Notwithstanding what purports to be a different constitutional challenge, the equal protection argument advanced by petitioners before this Court is essentially identical to that presented to the New Jersey courts and the decisions of those courts apply with equal force and effect to refute petitioners' position.

As noted in the opinion of the trial court, the decisions of this Court have conclusively established that the state has the unquestioned power to legislate in the area of public health. *Williamson v. Lee Optical of Okla.*, 348 U.S. 483 (1955). Equally well-established is the fact that in the field of insurance, "the power of the state is broad enough to take over the whole business, leaving no part for private enterprise." *California Auto. Asso. v. Maloney*, 341 U.S. 105, 110 (1951); *Osborn v. Ozlin*, 310 U.S. 53, 66 (1940).

In New Jersey, rather than preempt the health insurance field entirely, *cf. Independent Service Corporation v. Tousant*, 56 F. Supp. 75 (D. Mass. 1944), *aff'd*, 149 F.2d 204 (1st Cir. 1945), the Legislature has chosen to enact the Hospital Service Corporation Act, *supra*, which is designed particularly to accomplish the purpose of a broad based community health program, *i.e.*, to satisfy the needs of the hospitals and the community as a whole through a partnership between hospitals and nonprofit prepayment plans. The goals and objectives of this partnership are

2. Petitioners have also argued that the Commissioners have violated the statutory mandate which "requires" them "to consider the total costs necessary to maintain solvency of respondent hospitals." (P10). This is a question of State law and the final authority to determine the issue resides with the New Jersey courts. In its opinion, the Supreme Court of New Jersey held that the method of calculation "does take into consideration the total expenses of the hospital. . . ." (P24). Thus, this issue has been determined and is not properly before this Court.

(a) to provide to the public a payment-in-advance method for financing care provided by hospitals and to guarantee payment to the hospitals; (b) to make hospital care needed by the public financially accessible to the largest number of people at the lowest possible cost; and (c) to help the community carry the social and economic burden created when people are unable to pay for the necessary care rendered by hospitals (P43a).

Petitioners, however, are not involved in this partnership and therefore are not subject to the same burdens, restrictions and public control of their operations which membership in the partnership entails. These burdens include limitations on administration expenses (*N.J.R.S.* 17:48-10), restrictions on investments (*N.J.R.S.* 17:48-10), requirements as to composition of board of directors (*N.J.R.S.* 17:48-5), limitations on termination of coverage, refusal to renew coverage, selection of risks and underwriting classifications (*N.J.R.S.* 17:48-6), and other limitations described by the trial court (P43a). One can only speculate as to what petitioner welfare fund's response would be if State legislation were enacted imposing controls on the benefits it must offer, its spending and investment activities and its other operations similar to the controls imposed on Blue Cross under existing law. If petitioner trustees believe they are being discriminated against because of their refusal to participate in the Blue Cross program and their endeavor to establish their own more expensive program, then they only need apply to become a part of the Blue Cross group. In demanding that the hospitals charge them the same rate as Blue Cross, petitioners seek only the advantage of the comprehensive regulatory scheme without assuming any of the concomitant burdens associated with detailed regulation of their operations in the public interest, such as those outlined above.

The union welfare fund operates for the private interest of the individual members and not, as Blue Cross, for the benefit of the public at large. The clear factual differences in purpose and operation between Blue Cross and the union welfare fund make the difference in classification for hospital reimbursement purposes a permissible one under the Constitution. In fact, petitioners have failed to appreciate the importance of the continued existence of the Blue Cross (and Medicare) systems to the continued control of health facility costs in view of the fact that, without Blue Cross or Medicare, many patients whose hospital bills are paid by Blue Cross or Medicare might not be able to pay part or any of their hospital bills, thus increasing the "burden" of caring for indigents far beyond the reimbursement differential. See the reference to the coverage of poor risk subscribers in *Travelers Ins. Co. v. Blue Cross of West Pennsylvania*, 481 F.2d 80, at 82 n.8 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973).

In summary, the petitioners' complaint of an invalid legislative or administrative classification flies in the face of well-established and unquestioned constitutional principles. The fact that the Legislature classifies hospital service corporations differently from other third party payers and private patients with regard to the reimbursement of the hospitals is "not palpably arbitrary" but is "reasonably based on a substantial difference or distinction" which is "rationally related to a legitimate statutory objective or purpose." [3] Not every inequality offends the constitutional provisions of due process and equal protection. *City of New Orleans v. Dukes, supra* (The Court in up-

3. Similarly, Congress has required that payments to participating hospitals for hospital services to Medicare beneficiaries be made solely on the basis of "reasonable costs" rather than on the basis of charges to the public. 41 U.S.C.A. §1395f(b); 20 C.F.R. §405.401(a).

holding an economic regulation stated that "[s]tates are accorded wide latitude in the regulation of their local economies under their police powers, and rational distinctions may be made with substantially less than mathematical exactitude." *Id.* at 5076); *Dandridge v. Williams*, 397 U.S. 471, 485 (1970); *Lindsley v. Natural Carbonic Gas Co.*, 220 U.S. 61, 78-79 (1911).

The recent case of *Travelers Ins. Co. v. Blue Cross of West Pennsylvania*, *supra* at pp. 85 and 86, quickly rejected the argument that the reimbursement differential between Blue Cross and private hospital payers violated the equal protection requirement. *Cf. Clarke v. Redeker*, 259 F. Supp. 117, 122 (S.D. Iowa 1966) in which it was held that it is constitutionally permissible for a state university to charge non-residents higher tuition than residents as a reasonable attempt to achieve the permissible goal of cost equalization.

Petitioners have failed to carry the burden of showing that the classification, legislative or administrative, which results in favorable benefits to hospital service corporations such as Blue Cross does not bear a reasonable relation to a permissible legislative objective, *West Coast Hotel Company v. Parrish*, 300 U.S. 379, 391 (1937), and is essentially arbitrary. *Goldblatt v. Town of Hempstead*, 369 U.S. 590 (1962); *Lindsley v. Natural Carbonic Gas Co.*, *supra* at 78-79. If any state of facts reasonably may be conceived to justify the distinction, the statute will be upheld. *City of New Orleans v. Dukes, supra; Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976); *Dandridge v. Williams*, *supra* at 486-87, *Metropolitan Casualty Ins. Co. v. Brownell*, 294 U.S. 580 (1935). Specifically, petitioners have failed to demonstrate that the Legislature, in writing enabling legislation for hospital service corporations, and the Commissioners in administering the legislation, have estab-

lished an arbitrary classification of the respective groups and that the statutorily sanctioned difference in treatment of Blue Cross (the largest hospital service corporation in New Jersey) bears no rational relation to legitimate legislative objectives.

Whether the State has chosen wisely or foolishly in creating and regulating Blue Cross in its relationship with the hospitals is not a concern for this Court; it is sufficient that the objective—community-wide health financing—is permissible and the scheme reasonably related to the objective. *See Osborn v. Ozlin, supra.*

In *Associated Hospital Service, Inc. v. Milwaukee, supra*, the Wisconsin Supreme Court considered whether the tax exemption granted the Blue Cross plan resulted in an unreasonable classification violative of the equal protection clause of the Fourteenth Amendment. In particular, the City of Milwaukee argued that an arbitrary and unconstitutional classification is made by the statute in granting exemption to the property of Blue Cross and not to that of insurance companies. The court, after discussing the history and background of Blue Cross and the purposes and objectives to which it is dedicated, noted the "marked difference in method of operation between a Blue Cross hospital service corporation and a commercial insurance company that sells hospital care indemnity insurance." 88 A.L.R. 2d at 1411. The court said:

> "The state's interest in protecting the financial status of its state, county, municipal, and voluntary nonprofit hospitals is a further justification for treating Blue Cross hospital service corporations differently taxwise than it does commercial insurance companies writing hospital care indemnity insurance." *Id.* at 1412.

The court concluded:

> "Enough has been said to indicate that the classification made by (the statute) does rest upon real differences existing between non-profit hospital service corporations and commercial insurance companies writing hospital care indemnity insurance. Therefore, such statute does not impose an arbitrary unreasonable classification and is constitutional." *Id.*

For purposes of this petition it may be assumed *arguendo* that petitioner-trustees, in attempting to provide a health service benefits program to members of the union, are at a competitive disadvantage vis-a-vis Blue Cross to the extent that the latter pays less per patient than the petitioner-trustees. However, given the public and quasi-public nature of the entire hospital service corporation system—especially the Blue Cross-member hospital relationship as controlled and regulated by the Commissioners—it is apparent that the trustees are complaining of an unequal competitive environment created by and maintained by the State. No constitutional doctrine requires that the State permit free competition or refrain from competing with private concerns especially in an area of such public concern as health financing for the community. *Cf. Tennessee Electric Power Co. v. T.V.A.*, 306 U.S. 118, 138-40 (1939) (private utility complains of T.V.A. competition and T.V.A.'s ability to offer lower rates); *Madera Waterworks v. Madera*, 228 U.S. 454, 456 (1913); *Helena Waterworks Co. v. Helena*, 195 U.S. 383, 388 (1904); *Joplin v. Southwest Missouri Light Co.*, 191 U.S. 150 (1903). *Cf. Hardin v. Kentucky Utilities Co.*, 390 U.S. 1 (1968) (T.V.A. competition).

Notwithstanding its power to do so, in creating hospital service corporations and in regulating their reimbursement of hospitals, the State of New Jersey has not sought to forbid or destroy competition among other organizations wishing to provide health insurance or health

service benefits. Neither has the State required all persons to purchase Blue Cross insurance or forbidden others to act as third party payers. Rather, the statute creating the Blue Cross program provides certain benefits to and imposes certain burdens on Blue Cross so as to enable it to accomplish its statutory purposes. The fact that in so doing the petitioners' welfare plan has been put at a competitive disadvantage does no violence to the Constitution. *Cf. City of New Orleans v. Dukes, supra; Independent Service Corporation v. Tousant, supra. See also Virgo Corporation v. Paiewonsky*, 384 F.2d 569 (3d Cir. 1967), *cert. denied*, 390 U.S. 1041 (1968) (one of four competitors may be denied subsidies granted to others where, in view of public purpose of subsidy program, classification was not "patently arbitrary").

Respondent hospitals' contentions do not relate to the issues pertinent to the companion case, *Borland v. McDonough*, 135 N.J. Super. 200 (App. Div. 1975), *aff'd*, 52 N.J. 152 (1977), *petition for cert. filed*, 45 U.S.L.W. 3707 (U.S. April 26, 1977), and which are set forth in the Fourth and Fifth Counts of the Complaint where it is alleged that the particular rates approved by the Commissioners fail to take into account certain items of necessary hospital expenses. The hospitals themselves have reserved the right to raise these same issues regarding the elimination of costs at the appropriate time in actions solely against the Commissioners of Insurance and Health and against Blue Cross.[4]

4. At least two New Jersey hospitals have in fact instituted suit with respect to disallowance by the Commissioners of eligible costs for previous years. *Newark Beth Israel Medical Center v. Sheeran*, Docket No. A-785-74 (App. Div. Super. Ct., June 11, 1976); *West Jersey Hospital v. Hospital Service Plan of New Jersey*, Docket No. A-2002-74 (App. Div. Super. Ct.).

II. ALL PARTIES HAVING ADMITTED THE EXISTENCE OF A DIFFERENTIAL BETWEEN THE BLUE CROSS REIMBURSEMENT RATE AND THE CHARGES TO NONSUBSCRIBERS, AND PETITIONERS HAVING FAILED TO SHOW (I) THE EXISTENCE OF ANY GENUINE MATERIAL ISSUES OF FACT AND (II) ANY CONNECTION BETWEEN THE HOSPITALS AND THE ALLEGED ARBITRARY EXCLUSION OF COSTS BY THE COMMISSIONERS OF HEALTH AND INSURANCE, THE LOWER COURTS WERE CORRECT IN VIEWING THE CASE AS APPROPRIATE FOR DISPOSITION ON RESPONDENT HOSPITALS' MOTION TO DISMISS.

In moving before the trial court to dismiss petitioners' Complaint as to them, respondent hospitals conceded the differential in rates and contended that since the rates are set by the Commissioners, as a matter of law this differential gave rise to a claim against the Commissioners but not against respondent hospitals. Petitioners have failed to show how discovery of the precise elements of cost which result in the rate differential or how discovery of the elements excluded from the Blue Cross reimbursement rates would have had any impact on the decision of the trial court in granting summary judgment in favor of respondent hospitals.

With respect to the resolution of petitioners' complaint against respondent hospitals, it is sufficient that the hospitals admit the differential between the rate charged petitioners and the Blue Cross rate. The fact that respondent hospitals are affected by the Blue Cross reimbursement rates and are required to submit data used in

the rate-making process does not lead to the conclusion that the hospitals are parties with respondent Commissioners in an allegedly unconstitutional administration of the statutory scheme. Any allegation of such concerted activity or commonality of purpose and action flies in the face of all logic and was in fact found by the trial judge to be "spurious" (P39a). The decisions in the courts below not permitting petitioners discovery were based upon New Jersey court rules and case law which comply with the due process requirements of the Fourteenth Amendment. *Cf. Banco De Espana v. Federal Reserve Bank of New York*, 28 F. Supp. 958 (S.D. N.Y. 1939), *aff'd.*, 114 F.2d 438 (2d Cir. 1940); *Beidler & Bookmyer v. Universal Ins. Co.*, 134 F.2d 828 (2d Cir. 1943).

Reason dictates that rather than seeking to exclude costs, the hospitals would do everything in their power to have all costs considered and included in establishing the reimbursement rate. It is *against* the interests of the hospitals to agree to rates which result in recovery of less than all costs. For many hospitals, particularly those in large urban areas, the charges paid by non-Blue Cross subscribers are not nearly sufficient to cover the deficits resulting from losses incurred in treating the indigents which are not included in the Blue Cross reimbursement rate calculation.

Petitioners, without any supporting evidence, attempt to portray the Commissioners as inactive rubber stamps of the decisions of the hospitals and Blue Cross, and as performing mere ministerial functions in computing rates. This portrayal illustrates either a complete naivete as to the Commissioners' role in the Blue Cross process or a conscious attempt by petitioners to divert the Court's attention from the realities of the situation. In fact, the hospitals and Commissioners have been involved in virtually continuous disputes regarding certification of costs and establishment of reimbursement rates. Far from automatically approving the hospitals' rate requests, the Commissioners have forced hospitals into greater deficits by refusing to permit reimbursement for costs certified to have been incurred in categories eligible for reimbursement.

The basis to be used by the Commissioners in disallowing certified costs for 1975 was the essence of *Monmouth Medical Center v. State of New Jersey*, Docket No. A-2147-2154-74 (App. Div. Super. Ct., April 30, 1975) cited by petitioners (P8). In addition, at least two suits have been instituted by other hospitals (one a respondent in this case) with respect to the disallowance by the Commissioners of eligible costs for previous years. *Newark Beth Israel Medical Center v. Sheeran, supra; West Jersey Hospital v. Hospital Service Plan of New Jersey, supra.* Also, a new suit was recently instituted by the New Jersey Hospital Association on behalf of virtually all New Jersey hospitals against the Commissioners and Blue Cross seeking certification and full payment of reimbursable costs for the years 1971 through 1975. *New Jersey Hospital Association v. Hospital Service Plan of New Jersey*, Docket No. L-24750-76 (Super. Ct. Law Div., filed February 28, 1977).

Thus, far from being conspirators in a plot to depress Blue Cross reimbursement rates, the hospitals have been and continue to be the unwilling victims of the Commissioners' lack of responsiveness to the hospitals' needs. The hospitals receive no benefit from lower reimbursement rates, nor have petitioners attempted to cite any motive for the alleged conspiracy to depress such reimbursement rates. On the contrary, higher reimbursement rates are sought by every hospital. Any increase in reimbursement rates, however, must be reflected in increased premium charges to subscribers. Because of the vast number of

Blue Cross subscribers in New Jersey, any potential premium increase is fraught with substantial political and economic significance and receives front-page newspaper coverage throughout the State.

Thus, the Commissioners' refusal to permit hospitals to receive a rate which actually reimburses for costs is not the result of an abdication of a statutory function, but is an expression of a conscious political decision based on the simple fact that there are less than 150 hospitals in New Jersey, but approximately 4.4 million Blue Cross premium payers within the State. Any complaint which petitioners may have should therefore be addressed to the Commissioners in the companion case.

In addition to raising the specious issue of conspiracy and accusing the Commissioners of Health and Insurance of abdicating their responsibilities and permitting the hospitals and Blue Cross together to set the reimbursement rates, petitioners claim that other issues of fact exist since it must be determined what items are excluded in the establishment of the rate and why such items are excluded. While surely these are issues of fact relevant to the proceeding between petitioners and the Commissioners, they have no relevance to any claim which petitioners have against respondent hospitals. The hospitals have conceded the omission of certain items of cost in the determination of the reimbursement rate. The items were omitted, properly or improperly, by virtue of policy decisions made by the Commissioners of Health and Insurance who have been given the power by the Legislature to fix the rates. Why the Commissioners sought to exclude certain items is a matter that has no bearing on petitioners' claims against respondent hospitals.

Thus, it is submitted that petitioners have failed to establish the existence of any issues of fact warranting denial of respondent hospitals' motion to dismiss.

CONCLUSION

On the basis of the foregoing, it is respectfully submitted that the petitioners have failed to demonstrate any claim against the respondent hospitals appropriate for review by this Court. Any issues raised by petitioners relate only to the administration of the statutory scheme by the Commissioners of Health and Insurance. Accordingly, the instant petition for a writ of certiorari to the Supreme Court of New Jersey should be denied.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM 1977

No. 76-1412

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,
Petitioners,

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey
Respondents.

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,
Petitioners,

vs.

Richard McDonough, Commissioner of Insurance of the State of New Jersey, and James R. Cowan, M.D., Commissioner of Health of the State of New Jersey,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Does the Equal Protection or Due Process Clause of the Fourteenth Amendment to the United States Constitution prohibit the State of New Jersey from regulating only the hospital rates paid by hospital service corporations, leaving other hospital users subject to unregulated hospital charges?

COUNTERSTATEMENT OF THE CASE

Plaintiffs, trustees and an eligible beneficiary of a union welfare fund ("Union Representatives"), instituted suit against twenty-two New Jersey hospitals, the Hospital Service Plan of New Jersey ("Blue Cross"), and the New Jersey Commissioners of Insurance and Health for alleged unlawful discrimination as a result of higher rates charged to plaintiffs than to Blue Cross for identical hospital services (PC1a to PC20a). Because of the rate differential, the hospitals and the Commissioners were alleged to have violated plaintiffs' state and federal constitutional rights of equal protection and due process of law. The Union Representatives also claimed that either the Commissioners had improperly construed and applied the New Jersey statutes governing administrative approval of Blue Cross hospital reimbursement rates or that those statutes were repugnant to the Equal Protection Clause of the Fourteenth Amendment (PC16a to PC18a).

Without deciding at that point the action against the Commissioners, the trial court granted summary judgment in favor of defendant hospitals and defendant Blue Cross. *Borland v. Bayonne Hospital*, 122 N.J. Super. 387, 300 A.2d 584 (Ch. Div. 1973) (PC32a to PC54a). The fact that the Union Representatives and others were charged more by these particular hospitals than the reimbursement rates received from Blue Cross and approved by the Commissioners of Insurance and Health was admitted. *Id.* at 393, 300 A.2d at 587 (PC36a). The separate statutory classification of nonprofit hospital service plans like Blue Cross, regulated under the provisions of the Hospital Service Corporations Act, *N.J.S.A.* 17:48-1 *et seq.*, and the rate differential resulting from regulatory approval of only the hospital reimbursement rates paid

by such plans were held to be permissible under state and federal constitutional law. *Id.* at 396-403, 300 A.2d at 588-92 (PC39a to PC47a). Endorsing the comprehensive reasoning and analysis of the trial court's opinion, the Appellate Division of the Superior Court affirmed per curiam. *Borland v. Bayonne Hospital*, 136 N.J. Super. 60, 344 A.2d 331 (App. Div. 1975) (PC81a).

The action of the Union Representatives against the Commissioners of Insurance and Health pursued a different route through the New Jersey courts for jurisdictional reasons. On motion of the Commissioners, the trial court transferred that portion of the action to the Appellate Division of Superior Court, which has exclusive jurisdiction over challenges to administrative actions of State agencies (PC61a). See *N.J. Ct. R.* 2:2-3(a)(2). The Appellate Division subsequently ordered the matter remanded to the Commissioner of Insurance for an expansion of the record, particularly with respect to the methods used and factors considered in approving Blue Cross hospital reimbursement rates as required by statute (PC62a). The Union Representatives' constitutional challenge to the rate differential was rejected for the reasons stated by the trial court in the companion action against the hospitals and Blue Cross. *Borland v. McDonough*, 135 N.J. Super. 200, 202, 343 A.2d 97, 98 (App. Div. 1975) (PC82a). Reviewing the expanded record, the court also rejected arguments by the Union Representatives that Blue Cross hospital reimbursement rates had been approved in violation of statutory requirements and under guidelines that were unduly vague. *Id.* at 202-203, 343 A.2d at 98-99 (PC83a to PC84a). Although the provisions of *N.J.S.A.* 26:2H-18 (d) require the Commissioners to "take into consideration the total costs of the health care facility," the court held that this language could not be read, as the Union Representatives

contended, to mandate rates that reimburse hospitals for their total cost outlay (which would include costs unrelated to care for Blue Cross subscribers). *Id.* In upholding the challenged administrative actions, the court noted that the legislative system obviously relies upon the Commissioners' expertise and the proper use of discretion in a very complex area, the exercise of which is expressly subject to judicial review. *Id.* at 203, 343 A.2d at 99 (PC84a).

The appeals of the Union Representatives from the decisions below in favor of Blue Cross and the hospitals and the decision in favor of the Commissioners were decided together by the Supreme Court of New Jersey. *Borland v. Bayonne Hospital*, 72 N.J. 152, 156, 369 A.2d 1, 2 (1977) (PC22). The decisions were affirmed for the reasons given below, but the court added its own particular reasons for rejecting the constitutional challenges of the Union Representatives. *Id.* Due process of law was held not to require a plenary hearing and discovery on the rate approval process because the rate differential of defendant hospitals was conceded as a fact and because the record, as expanded below, sufficiently detailed the method and procedure used in determining Blue Cross reimbursement rates to provide an adequate exposure to the statutory program as administered and implemented. *Id.* at 156-57, 369 A.2d at 3 (PC23 to PC24). Nor did the record establish the contention of the Union Representatives that the exclusion of particular operating expenses, after consideration of a hospital's total costs, in approving the Blue Cross hospital reimbursement rates was arbitrary or unreasonable. *Id.* at 157-58, 369 A.2d at 3 (PC24). The court noted that "the excluded expenses either do not involve services rendered Blue Cross subscribers, are items of expense for which recovery is had from other sources, or are not for services for which Blue Cross is

billed at a different rate." *Id.* at 157, 369 A.2d at 3 (PC24) (footnote omitted). Finally, the separate statutory classification of hospital service corporations like Blue Cross and the regulation of the rates of hospital reimbursement by such corporations without regulation of hospital charges to the general public was held to be consonant with equal protection to all hospital users. *Id.* at 159, 369 A.2d at 4 (PC26).

ARGUMENT

The Petition for a Writ of Certiorari should be denied because the method employed by the New Jersey Commissioners of Insurance and Health in approving the reasonableness of Blue Cross hospital reimbursement rates under statutes limiting such approval to the rates of hospital service corporations clearly does not deny equal protection or due process of law to other hospital users.

The decision below of the Supreme Court of New Jersey has conclusively established, as a matter of state law, that the complex administrative process used in implementing the statutes governing approval of Blue Cross hospital reimbursement rates is reasonable and consistent with legislative intent. *Borland v. Bayonne Hospital*, 72 N.J. 152, 157-58, 369 A.2d 1, 3-4 (1977) (PC24 to PC25). And the factual basis of the Union Representatives' constitutional challenge is not in dispute: the particular hospitals that are parties to this action charge more to others for services than the regulated reimbursement rates they receive from Blue Cross for services to its subscribers. *Id.* at 157, 369 A.2d at 3 (PC23 to PC24). Thus the precise constitutional issue that petitioners ask this Court to review is whether the Due Process and Equal Protection clauses of the federal constitution permit New Jersey to regulate hospital charges only with respect to hospital service corporations, leaving others subject to unregulated hospital charges.

Blue Cross is a qualified hospital service corporation regulated by the New Jersey Commissioner of Insurance under the provisions of the Hospital Service Corporations Act, *N.J.S.A.* 17:48-1 *et seq.* That Act has established a comprehensive regulatory mechanism designed to facilitate

the establishment of plans for furnishing prepaid hospital service benefits at a reasonable cost to those who choose to subscribe to such plans. Numerous provisions of the Act are clearly intended to assure that the interests of the subscribing public are protected in realizing the legislative goal. Thus hospital service corporations are deemed charitable institutions, exempt from most state and local taxes, that must be nonprofit and operated for the benefit of subscribers. *N.J.S.A.* 17:48-1, -2 and -18. Corporate bylaws must provide for proportionate representation on the board of directors by persons representing subscribers, the general public, and the contracting hospitals. *N.J.S.A.* 17:48-5. Subscriber contracts must include certain mandatory provisions, and the contractual forms and rates must be approved by the Commissioner of Insurance. *N.J.S.A.* 17:48-6 to 6.5,-6.9, -8 and -9. A hospital service corporation must maintain a minimum contingent surplus fund, and its solicitation and administration expenses cannot exceed certain fixed percentage limits. *N.J.S.A.* 17:48-10. In addition to being required to file annual financial statements, a hospital service corporation may be examined by the Commissioner of Insurance at any time concerning its finances, methods of doing business and all other affairs. *N.J.S.A.* 17:48-11 and -12. Furthermore, the Commissioner may seek injunctive relief or the appointment of a receiver whenever a hospital service corporation becomes insolvent, exceeds its powers, violates the law or operates in a manner hazardous to the public. *N.J.S.A.* 17:48-13.

In order to supplement the regulation of subscriber rates, the Legislature has granted regulatory authority over the reimbursement rates paid to hospitals for subscriber services. The constitutional challenge of the Union Representatives centers on the statutory provisions that require

hospital reimbursement rates of hospital service corporations to be "approved as to reasonableness" by the Commissioners of Insurance and Health. *N.J.S.A.* 17:48-7 and *N.J.S.A.* 26:2H-18(d). Except for these statutes regulating the reimbursement rates of hospital service corporations, hospital charges to the general public, insurance companies and other health care plans are unregulated in the State of New Jersey.* Although *N.J.S.A.* 17:48-7 prohibits noncontracting hospitals from charging a hospital service corporation rates that exceed its regular charges to the general public, the statutes do not compel a rate differential. A hospital and a group benefit plan (like that represented by the Union Representatives) are free to negotiate a rate equal to or below that paid by Blue Cross, which might reflect, for example, the magnitude of hospital use and the promptness of payment.

In assailing the constitutionality of the statutes that limit the regulation of hospital charges to the rates paid by hospital service corporations without similar regulatory authority over the rates paid by others, the Union Representatives suggest that the classification is arbitrary and that there is no rational basis for distinguishing the regulated health plans from those offered by union welfare funds. Although it is rather unusual for unregulated persons or entities to challenge state regulation that does not extend to them, it is well established that a State Legislature may regulate one kind of entity while exempting another type engaged in the same business without thereby denying equal protection. *Springfield Gas & Elec. Co. v. City of Springfield*, 257 U.S. 66 (1921); *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389 (1914). *See also Lehnhausen v. Lake Shore Auto Parts Co.*, 410 U.S. 356 (1973) (disparate tax treatment). In order to successfully overturn a statute on equal protection grounds, one must show that the challenged classification rests on grounds wholly unrelated to the achievement of valid state objectives. *Reed v. Reed*, 404 U.S. 71, 75-76 (1971); *Turner v. Fouche*, 396 U.S. 346, 362 (1970). Furthermore, the constitutionality of a legislative classification is presumed, and must be upheld if any state of facts can reasonably be conceived to support it. See *Dandridge v. Williams*, 397 U.S. 471, 485-87 (1970). A statute should not be overthrown because there are other instances to which it might have been applied. *West Coast Hotel Co. v. Parrish*, 300 U.S. 379, 400 (1937). See also *McGinnis v. Royster*, 410 U.S. 263, 276 (1973) (noting that the Court will not pick and choose among legitimate legislative aims to determine which is primary).

* There is one other exception: The Commissioner of Health also has authority to regulate the rates paid by governmental agencies. *N.J.S.A.* 26:2H-18(b).

The conclusion of the Legislature that there was a need for comprehensive State regulation of a particular category of health care plans and the hospital rates paid by such plans must be accepted. That the State Legislature might have chosen to implement a broader social objective by regulating all conceivable varieties of health benefit plans or the rates charged to all categories of hospital users will not vitiate the separate and reasonable classification of hospital service corporations. The Union Representatives' welfare fund provides health care benefits through a mechanism that is not subject to state regulatory controls. In contrast to the strict regulatory limitations upon hospital service corporations, the way in which such union welfare funds are operated, the kinds of benefits provided, the rate of contributions by employers or employees as well as the rates of payment to hospitals are all beyond the pale of state supervision. Significantly, the

Union Representatives have made no claim that hospital benefits at rates regulated under the Hospital Service Corporations Act are unavailable to them. Any corporation organized to provide a hospital service plan as set forth in the act, may qualify for a certificate of authority to do business thereunder. *N.J.S.A.* 17:48-1 and -3. The Union Representatives do not claim to have been denied approval to provide hospital benefits through such a qualified corporation. *Cf. Hendrick v. Maryland*, 235 U.S. 610, 621 (1915). Nor do they contend that they have been unable to purchase hospital service benefits through group or individual contracts issued by Blue Cross at rates regulated under the Hospital Service Corporations Act. See *N.J.S.A.* 17:48-6.1(a) (authorizing the issuance of group contracts to labor union trust funds). When there is no insurmountable barrier to obtaining the benefits of a particular classification and state law provides reasonable ways in which to qualify for such benefits, there is no denial of equal protection to members of the excluded class. See *Labine v. Vincent*, 401 U.S. 532, 539 (1971). Simply stated, the Union Representatives have opted to provide hospital benefits through an entity neither qualified nor regulated under the challenged statutes.

The State of New Jersey regulates the hospital reimbursement rates of hospital service corporations without extending equivalent regulation to other entities and persons who pay for hospital services. Even assuming that the economic effect of that distinction could give rise to an equal protection claim, it is clear that the particular circumstances of this case do not warrant further review by the Court. The Union Representatives have made no serious attempt to argue that the relevant statutes are unconstitutional on their faces; rather, their attack focuses on "the actual administration of the statutory scheme" (PC 16). Indeed, despite the clear holdings to the contrary

by the appellate courts of New Jersey, the Union Representatives continue to charge the Commissioners of Insurance and Health with "abrogating and ignoring their statutory duty." *Id.* Such contentions were unanimously rejected in each of the New Jersey appellate courts—rejections that rested on a detailed examination of an elaborate record establishing the complex method used to determine Blue Cross reimbursement rates at twenty-two New Jersey hospitals over a ten-year period. Expansion of the Record on Remand, filed September 6, 1974. Further examination by the Supreme Court of the United States to determine the reasonableness of these administrative rate calculations, tendered for review under the label of a denial of equal protection and due process, is clearly not warranted.

CONCLUSION

It is respectfully submitted for the foregoing reasons that the petition for a writ of certiorari should be denied.

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October Term, 1976

No. 76-1412

JOHN BORLAND, JR., J. BARRON LEEDS, LOUIS POLEVOY, IRVING KAPLAN, IRVING LEVY, JOHN NICCOLLAI, As Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and HOWARD MARKS,

Petitioners,

vs.

BAYONNE HOSPITAL, BERGEN PINES COUNTY HOSPITAL, BETH ISRAEL HOSPITAL, CLARA MAASS MEMORIAL HOSPITAL, ENGLEWOOD HOSPITAL

(Continued on Reverse)

On Petition for Writ of Certiorari to the Supreme Court of the State of New Jersey

BRIEF IN OPPOSITION FOR RESPONDENT, HOSPITAL SERVICE PLAN OF NEW JERSEY (NEW JERSEY BLUE CROSS PLAN) (IMPROPERLY DESIGNATED AS THE BLUE CROSS-BLUE SHIELD PLAN OF NEW JERSEY)

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Respondents.

JOHN BORLAND, JR., J. BARRON LEEDS, LOUIS POLEVOY, IRVING KAPLAN, IRVING LEVY, JOHN NICCOLLAI, As Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and HOWARD MARKS,

Petitioners,

vs.

RICHARD MC DONOUGH, Commissioner of Insurance of the State of New Jersey, and JAMES R. CO'NAN, M.D., Commissioner of Health of the State of New Jersey,

Respondents.

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BAYONNE HOSPITAL, BERGEN PINES COUNTY HOSPITAL, BETH ISRAEL HOSPITAL, CLARA MAASS MEMORIAL HOSPITAL, ENGLEWOOD HOSPITAL ASSOCIATION, GREATER PATERSON GENERAL HOSPITAL, HACKENSACK HOSPITAL, IRVINGTON GENERAL HOSPITAL, HOLY NAME HOSPITAL, THE HOSPITAL CENTER AT ORANGE, MONMOUTH MEDICAL CENTER, MORRISTOWN MEMORIAL HOSPITAL, MOUNTAINSIDE HOSPITAL, NEWARK BETH ISRAEL MEDICAL CENTER, RIVERDELL HOSPITAL, SADDLE BROOK HOSPITAL, SAINT

BARNABAS MEDICAL CENTER, ST. MICHAEL'S MEDICAL CENTER, SOUTH AMBOY MEMORIAL HOSPITAL, ST. JOSEPH'S HOSPITAL, ST. MARY'S HOSPITAL OF HOBOKEN, ST. MARY'S HOSPITAL OF PASSAIC, THE BLUE CROSS-BLUE SHIELD PLAN OF NEW JERSEY, a corporation of the State of New Jersey,

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RICHARD MC DONOUGH, Commissioner of Insurance of the State of New Jersey, and JAMES R. COWAN, M.D., Commissioner of Health of the State of New Jersey,

Respondents.

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BRIEF IN OPPOSITION FOR RESPONDENT, HOSPITAL SERVICE PLAN OF NEW JERSEY (NEW JERSEY BLUE CROSS PLAN) (IMPROPERLY DESIGNATED AS THE BLUE CROSS-BLUE SHIELD PLAN OF NEW JERSEY)

OPINIONS BELOW

The opinion of the Supreme Court of the State of New Jersey in *Borland v. Bayonne Hospital* is reported at 72 N.J. 152, 369 A.2d 1 (1977) (reprinted as Addendum A to Petition).

The opinion of the Superior Court of New Jersey, Appellate Division, in *Borland v. McDonough* is reported at 135 N.J. Super. 200, 343 A.2d 97 (App. Div. 1975) (reprinted at page 82a of Appendix to Petition).

The opinion of the Superior Court of New Jersey, Appellate Division, in *Borland v. Bayonne Hospital* is reported at 136 N.J. Super. 60, 344 A.2d 331 (App. Div. 1975) (reprinted at page 81a of Appendix to Petition).

The opinion of the Superior Court of New Jersey, Chancery Division, in *Borland v. Bayonne Hospital* is reported at 122 N.J. Super. 387, 300 A.2d 584 (Ch. Div. 1973) (reprinted at page 32a of Appendix to Petition).

QUESTION PRESENTED

Does a state statutory program which permits the operation of a closely regulated, non-profit hospital service prepayment plan to promote a broad based community health program violate the Equal Protection or Due Process Clauses of the Fourteenth Amendment because the rates at which the plan is permitted to reimburse hospitals for certain services are less than those charged by hospitals to other users for the same services?[1]

1. Petitioners also attempt to claim a denial of procedural due process by entry of a summary judgment in favor of respondent hospitals and Blue Cross.

(Cont'd)

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

The pertinent constitutional provisions are the Due Process and Equal Protection Clauses of Section 1 of the Fourteenth Amendment to the United States Constitution.

The pertinent statutory provisions are N.J.S.A. 17:48-1 *et seq.*, particularly N.J.S.A. 17:48-7, and N.J.S.A. 26:2H-1 *et seq.*, particularly N.J.S.A. 26:2H-18)(b)(c) and (d) (Supp. 1977).[2]

(Cont'd)
This claim is wholly without merit. *Bon Air Hotel, Inc. v. Time, Inc.*, 426 F.2d 858 (5th Cir. 1970); *United States v. Wood, Wire & Metal Lath Int. U., Loc. No. 46*, 471 F.2d 408 (2nd Cir. 1973), *cert. denied*, 412 U.S. 939 (1973).

2. Article 1, Paragraph 1 of the New Jersey Constitution of 1947 which is cited by petitioners, has been interpreted to include state due process and equal protection rights. *Auto-Rite Supply Co. v. Mayor and Tp. Committeemen of Woodbridge Tp.*, 41 N.J. Super. 303, 311, 124 A.2d 612, 616 (1956). This provision is no longer involved in this case, however. R. 2:2-3(a) (appeals to Appellate Division from final agency action) and R.4:46 (summary judgment) are procedural rules which are unimportant here. Petitioners cite the following provisions of the New Jersey Constitution of 1947 as also being pertinent: (a) Article 1, par. 6 (freedom of speech and press), (b) Article 1, par. 7 (freedom from unreasonable searches and seizures), (c) Article 1, par. 8 (right to presentment or indictment of a grand jury), and (d) Article 1, par. 9 (right to trial by jury). These provisions are totally irrelevant. Petitioners also cite Article I §20 of the New Jersey Constitution of 1947 which prohibits the taking of private property for public use without just compensation. Petitioners' argument on this point is frivolous. The importance of N.J.S.A. 52:14B-1 *et seq.* and N.J.A.C. 8:31-14.4, cited by petitioners, is not at all apparent. The statute deals only with the procedure for agency enaction of rules. The regulation provides that initial 1975 rates shall be based upon elements of costs approved by the Commissioner of Health. Petitioners also cite 29 U.S.C. §147 *et seq.*, which appears to be a printing error, because no statute appears to have ever been so codified.

STATEMENT OF THE CASE

This litigation concerns the differential in rates charged by respondent hospitals to Blue Cross for services rendered to Blue Cross subscribers, as compared with the rates charged by respondent hospitals to members of the public who are not Blue Cross subscribers. Petitioners are individual members and trustees of a union welfare fund which pays for services rendered by respondent hospitals at the same rates charged by such hospitals to commercial carriers and to other members of the general public who are not Blue Cross subscribers. Those rates are generally higher than those charged Blue Cross for certain services rendered by member hospitals to Blue Cross subscribers. *Borland v. Bayonne Hospital*, 122 N.J. Super. 387, 394 (Ch. Div. 1973).[3] Petitioners assert that this rate differential amounts to a deprivation of their due process and equal protection rights under Section 1 of the Fourteenth Amendment to the United States Constitution.

Proceedings Before the Courts Below

Respondent hospitals moved before the trial court to dismiss the complaint for failure to state a cause of action against them on the grounds that the Blue Cross reimbursement rate is controlled by the Commissioners of Insurance and of Health. Blue Cross moved for summary judgment. The trial court treated the hospitals' motion as one for summary

3. Although for purposes of an application for summary judgment the trial court noted that the difference in rates was said to approximate 20%, *Borland v. Bayonne Hospital*, 122 N.J. Super. 387, 394 (Ch. Div. 1973), there was no specific finding on the amount of the differential in rates.

judgment and, after briefs and oral argument, granted summary judgment to respondent hospitals and to Blue Cross. Petitioners appealed this judgment to the Appellate Division of the Superior Court of New Jersey.

Respondents, Commissioners of Insurance and of Health, then moved to have the remainder of the case transferred to the Appellate Division of the Superior Court of New Jersey on the grounds that petitioners' assertions amounted to an appeal from the final determination of an administrative agency. R.2:2-3(a). That motion was granted (Petitioners' Appendix, 61a). Upon application by petitioners, the Appellate Division remanded the case against the Commissioners to the Commissioner of Insurance for the purpose of expanding the record as to the method used and the factors considered by the Commissioners in establishing the rates payable by Blue Cross as required by N.J.S.A. 26:2H-18 (Petitioners' Appendix, 62a).

The Commissioner of Insurance filed the Expansion of the Record on Remand which was verified by the affidavit of the Commissioner of Insurance. After considering the Expansion of the Record on Remand, the Appellate Division of the Superior Court of New Jersey ruled in favor of the respondents, Commissioners of Insurance and of Health, *Borland v. McDonough*, 135 N.J. Super. 200, 343 A.2d 97 (App. Div. 1975) and affirmed the summary judgment in favor of respondent hospitals and Blue Cross for the reasons expressed in the opinion of the trial court. *Borland v. Bayonne Hospital*, 136 N.J. Super. 60, 344 A.2d 331 (App. Div. 1975).

Petitioners then appealed to the Supreme Court of New

Jersey which affirmed the judgments of the courts below in a single opinion. *Borland v. Bayonne Hospital*, 72 N.J. 152, 369 A.2d 1 (1977).

The Design and Nature of Blue Cross in Contrast to Petitioner's Union Welfare Fund

Blue Cross exists under the authority of the Hospital Service Corporation Act, N.J.S.A. 17:48-1 *et seq.*, which permits the formation and operation of a non-profit corporation, without capital stock, to establish a non-profit hospital service plan. N.J.S.A. 17:48-1 (Supp. 1977), N.J.S.A. 17:48-2. Blue Cross contracts with subscribers for hospital service benefits and with hospitals to pay for covered hospital services rendered to subscribers. A hospital service corporation such as Blue Cross is authorized by statute to contract with a participating hospital for "rates of payment . . . in the form of a level *per diem* amount established for the particular hospital . . . for each day of health care services . . . ." N.J.S.A. 17:48-7 (Supp. 1977). Payment by hospital service corporations for services rendered to its subscribers must be "at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health"[4] and "[i]n establishing such rates, the commissioners shall take into consideration the total costs of the health care facility." N.J.S.A. 26:2H-18(d) (Supp. 1977).

The design and purpose of the Hospital Service

4. Congress has similarly required that payments to hospitals for services to Medicare beneficiaries be on the basis of "reasonable costs." 41 U.S.C.A. §1395f(b); 20 C.F.R. 405.401(a).

Corporation Act, N.J.S.A. 17:48-1 *et seq.*, is that of a broad based community health program which aims to satisfy the needs of hospitals and the community as a whole through a partnership between hospitals and a non-profit prepayment plan. *Borland v. Bayonne Hospital,* 122 N.J. Super. 387, 398-99 (Ch. Div. 1973) and authorities there cited. The goals of this partnership are (a) to provide the public a payment-in-advance method for financing care provided by hospitals and to guarantee payment to the hospitals; (b) to make hospital care needed by the public financially accessible to the largest number of people at the lowest possible cost; and (c) to help the community carry the social and economic burden created when people are unable to pay for the necessary care rendered by hospitals. *Borland v. Bayonne Hospital,* 122 N.J. Super. 387, 399 (Ch. Div. 1973) and authority there cited; cf. *Johnson v. Hospital Service Plan of N.J.*, 25 N.J. 134, 144, 135 A.2d 483, 488 (1957).

To best achieve the desired goal of the Hospital Service Corporation Act, the Legislature subjected Blue Cross to stringent state regulation. It must be organized without capital stock and may not be operated for profit or converted into a corporation organized for profit. N.J.S.A. 17:48-1 (Supp. 1977); N.J.S.A. 17:48-2. It may not operate except under a Certificate of Authority approved by the Commissioner of Insurance of the State of New Jersey, who grants approval if the operation of the hospital service plan is in the public interest. N.J.S.A. 17:48-5. It can be operated only for the benefit of its subscribers, N.J.S.A. 17:48-2, and is strictly limited as to the expenditures it may make for solicitation of subscribers and for administration. N.J.S.A. 17:48-10. Its funds may be invested only as permitted

for investment of funds of life insurance companies operating under the laws of the State of New Jersey, and it must maintain a special contingent surplus over and above its reserves and liabilities. N.J.S.A. 17:48-10. It is also exempt from every state, county, district, municipal and school tax other than taxes on real estate and equipment. N.J.S.A. 17:48-18. The board of directors of Blue Cross must be composed of persons who are representative of the member hospitals of the corporation, its subscribers and the general public. N.J.S.A. 17:48-5 (Supp. 1977). The provisions of Blue Cross' contracts with its subscribers are subject to stringent statutory limitations, including a prohibition against termination of coverage, in the absence of fraud or material misrepresentation by the subscriber, unless all contracts of the same type are terminated. N.J.S.A. 17:48-6 (Supp. 1977). The practices, rules and procedures for termination, refusal to renew coverage, modification of coverage or rates, selection of risks and underwriting classifications are subject to review by the State Commissioner of Insurance. N.J.S.A. 17:48-6.8 (Supp. 1977).

By contrast, petitioner trustees are not subject to the strict statutory controls imposed upon hospital service corporations. Plaintiff trustees provide benefits to members of the welfare fund subject only to general fiduciary obligations and the requirements of the Welfare and Pension Fund Disclosure Act, 29 U.S.C.A. §301 *et seq.*[5] That Act requires only the disclosure of certain information and provides for enforcement of those

5. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, Title 1, §111(a)(1), 88 Stat. 851 (1974) repealed this chapter effective January 1, 1975, providing in part, however, that this chapter shall continue to apply to any conduct and events which occurred before January 1, 1975.

disclosure requirements. Furthermore, petitioner trustees operate not for the benefit of the general public, but for the benefit of the members of their own union welfare fund. Finally, petitioner trustees, if they so desired, could purchase Blue Cross benefits for the members of the union welfare fund under the same terms and conditions as others who are similarly situated.

Blue Cross Reimbursement Rates

Blue Cross reimbursement rates to hospitals are established by the Commissioner of Health and approved as to reasonableness by the Commissioner of Insurance. N.J.S.A. 26:2H-18(d). Blue Cross pays for covered outpatient services at the same rates as the general public and reimburses hospitals at a *per diem* rate for inpatient services. The *per diem* rate represents the average reimbursable cost per day for all hospital patients having characteristics consistent with those of patients who are Blue Cross subscribers.

The starting point for calculating the inpatient *per diem* rate for each hospital is the total expenses shown in the hospital's annual operating report. These total expenses are then reduced by the following:

1. cost of items that are normally subsidized,
2. types of expenses that actually result in non-operating income,
3. items of income which are actually a recovery of expenses,

4. cost of non-eligible services,
5. cash income from emergency care or alternative,
6. cost of outpatient care,
7. cost of home care and nursing home care.

Item one refers to research programs subsidized by special grants, donations, or funds. Item two refers to costs of operating coffee shops, gift shops, servicing of investments, solicitation of funds, and other programs which produce non-operating income. These items are eliminated because in a well-managed hospital, such programs should be self-supporting and have no impact on charges to any category of patients, whether it be Blue Cross subscriber or non-subscriber.

Item three includes types of income which are actually a recovery of expenses such as telephone income, laundry service provided at a charge to employees, meals for nurses, guests and employees, rental of quarters to employees and physicians, income from nurses' training schools, medical transcript fees and the like. These items are eliminated because Blue Cross should not be required to pay for hospital operations which are self-supporting and not included in the Blue Cross benefit package. It is also reasonable to exclude item 4, the cost of non-eligible services. Blue Cross subscribers pay such charges directly to the hospital.

The fifth, sixth and seventh items involve hospital operations related not to inpatient but to outpatient services for

which Blue Cross reimburses the hospital for eligible services on the basis of the hospital's general charges to the public. Therefore, they are not included in the calculation of the inpatient *per diem* rate (Expansion of the Record on Remand, 16-18).

The omission of these specified costs from the total hospital costs results in a particular *per diem* rate for inpatient services to Blue Cross subscribers which, contrary to petitioners' claims, fully reimburses the hospitals for services rendered to Blue Cross subscribers. The hospitals remain free to charge members of the public who are not Blue Cross subscribers at rates higher than those paid by Blue Cross.

On these facts, the Supreme Court of New Jersey unanimously and appropriately affirmed the rulings of the lower courts that petitioners' constitutional rights to equal protection and due process had not been violated.

ARGUMENT

I.

The decisions below are in accordance with applicable decisions of this Court and no issue is presented which this Court should review.

The statutes here involved are basically economic regulation of health care costs in the State of New Jersey. In economic regulation, this Court has persistently used a "rational basis" standard of review for governmental regulation and has not in

recent times struck down an economic regulation either on due process or equal protection grounds.[6] In *City of New Orleans v. Dukes*, 427 U.S. 297 (1976), this Court noted that economic regulations are subject to a deferential standard of review and that rational distinctions may be made with substantially less than mathematical exactitude. The economic regulation in *City of New Orleans*, which was not held to be violative of equal protection, resulted in a prohibition of the business activities of the plaintiff, a consequence which petitioners herein have not and will not experience under the state regulation involved in this case.

Petitioners cite *Reagan v. Farmers Loan & Trust Co.*, 154 U.S. 362 (1894) for the proposition that the decision of the courts below does not comport with the precedents of this Court. In that case, the facts of which are wholly distinguishable from those *sub judice*, a railroad commission set rates which a railroad could charge at such a low level as to diminish the earnings of the railroad to such an extent that the railroad would not have been able to pay the interest on its debt obligations. Petitioners here can make no such contention.

In attacking the statutory scheme in relation to the admitted present difference in rates for inpatient services as between subscribers to Blue Cross and non-subscribers, petitioners have the burden of showing that a classification exists which does not bear a reasonable relationship to a permissible legislative

6. The only case in recent times to strike down an economic regulation on equal protection grounds is *Morey v. Doud*, 354 U.S. 457 (1957), and this Court explicitly overruled that case last year in *City of New Orleans v. Dukes*, 427 U.S. 297 (1976).

objective and is essentially arbitrary. *Goldblatt v. Hempstead,* 369 U.S. 590 (1962); *Lindsley v. Natural Carbonic Gas Co.,* 220 U.S. 61, 78-79 (1911). A classification having some reasonable basis is not invalid merely because in practice it results in some inequality. *Dandridge v. Williams,* 397 U.S. 471 (1970). The classification must be upheld and a statutory discrimination will not be set aside if any set of facts can reasonably be conceived to support it. *Id.* at 485; *McGowan v. Maryland,* 366 U.S. 420, 426 (1961); *Metropolitan Casualty Ins. Co. v. Brownell,* 294 U.S. 580 (1935).

The stated principles are especially supportive here of the constitutionality of the legislative scheme because a state has unquestioned power to legislate in the area of public health. *Williamson v. Lee Optical of Oklahoma, Inc.,* 348 U.S. 483 (1955). Indeed, in the field of insurance, "the power of the state is broad enough to take over the whole business, leaving no part for private enterprise." *California State Auto. Assoc. Inter-Ins. Bureau v. Maloney,* 341 U.S. 105, 110 (1951); *Osborn v. Ozlin,* 310 U.S. 53 (1940). A state may require the purchase of insurance or its equivalent, *New York Central R. Co. v. White,* 243 U.S. 188, 208-09 (1917), and may compel health insurance supported by employer contributions or by taxes. Cf. *Mountain Timber Co. v. Washington,* 243 U.S. 219 (1917). The legislative objective here is unmistakenly salutary and based on desirable and reasonable goals.

The legislative program is also rationally related to achieving the unquestionably permissible legislative goals. Reimbursement to the hospitals by Blue Cross provides the public with a payment-in-advance method for financing hospital

care and guarantees payment to the hospitals.[7] The legislative program keeps the cost of hospital care down by requiring (a) that the hospital service plan be organized on a not-for-profit basis, N.J.S.A. 17:48-1 (Supp. 1977), (b) that it be operated only for the benefit of its subscribers, N.J.S.A. 17:48-2, (c) that its expenditures for solicitation of subscribers and for administration be strictly limited, N.J.S.A. 17:48-10, (d) that it be exempt from every state, county, district, municipal and school tax other than taxes on real estate and equipment, N.J.S.A. 17:48-18, and (e) that payment for hospital services by a hospital service corporation be made at reasonable rates. N.J.S.A. 26:2H-18(d) (Supp. 1977).

The financial integrity and the non-profit status of the hospital service plan are insured in part by limitations on the investment freedom of the plan, N.J.S.A. 17:48-10, and the requirement for maintenance of the special contingent surplus over and above reserves and liabilities. *Id.* Accessibility to the largest number of people is fostered by the fact that subscription is open to the public, by the fact that Blue Cross is prohibited from termination of coverage, in the absence of fraud or material misrepresentation by the subscriber, unless all contracts of the same type are terminated, N.J.S.A. 17:48-6 (Supp. 1977), and by the fact that the practices, rules and procedures for termination, refusal to renew coverage, modification of coverage or rates, selection of risks and underwriting classifications are

7. It is interesting to note that although the hospitals reserved the right to challenge the sufficiency of reimbursement by Blue Cross, *Borland v. Bayonne Hospital,* 122 N.J. Super. 387, 395 (Ch. Div. 1973), they support the constitutionality of the statutes involved here. See Brief in Opposition to Petition for Writ of Certiorari of Defendant-Respondent Hospitals, pp. 9-16.

subject to review by the State Commissioner of Insurance. N.J.S.A. 17:48-6.8 (Supp. 1977). Under the statutory scheme, Blue Cross furnishes prepaid hospital service benefits at a reasonable cost to those who choose to subscribe to such plan and, by extending coverage to poorer risks, assists the community in carrying the social and economic burden of those who otherwise might not be able to pay part or all of their hospital bills and who thus would increase the burden of caring for indigents far beyond the reimbursement differential. See *Travelers Ins. Co. v. Blue Cross of West Pennsylvania,* 481 F.2d 80 at 82 n.8 (3d Cir. 1973), *cert. denied,* 414 U.S. 1093 (1973).

Petitioners continue to contend that because certain hospital costs are omitted before computation of the *per diem* rate for inpatient services, the Commissioner is not complying with the legislative mandate of N.J.S.A. 26:2H-18 that in establishing reasonable rates, "the commissioners shall take into consideration the total costs of the health care facility." This is a question of state statutory interpretation which was properly decided by the New Jersey courts and is not an issue for this Court. *Borland v. McDonough,* 135 N.J. Super. 200, 202 (App. Div. 1975). The statute only requires that the Commissioner "take into consideration" the total costs of the hospital in approving the rates. This the Commissioner does by beginning the calculation of the *per diem* for inpatient services with total operating expenses of the hospital. Furthermore, there is ample reason, as noted, for omission of each of the types of costs which are deducted by the Commissioner from total hospital costs in calculating the *per diem* rate for inpatient services. Indeed, to require the Commissioner to include all costs in establishing the *per diem* rate for inpatient services would divest him of his

discretionary powers, reduce his task to mere mechanics and subvert the leglislative goal of control of rates at reasonable levels. Therefore, the method of calculating the inpatient *per diem* rate is not arbitrary.

The clear factual differences between Blue Cross and the petitioners' union welfare fund justify a difference in treatment as to rates paid for hospital services. In contrast to the purposes and goals of a hospital service plan, petitioners' union welfare fund is not organized for the benefit of the general public but to foster the private interests of its own members. The union welfare fund is not subject to the extensive state regulatory controls imposed upon Blue Cross. Plaintiff trustees provide benefits to members of the union welfare fund subject only to general fiduciary obligations and the requirements of the Welfare and Pension Fund Disclosure Act, 29 U.S.C.A. §301 *et seq.*, which requires only the disclosure of certain information. Thus, the union welfare fund and Blue Cross are not similarly situated and the difference in hospital rates between the two is a rational distinction which does not violate the due process or equal protection rights of petitioners.

CONCLUSION

For the foregoing reasons, petitioners present no special or important issue which this Court, in the exercise of its judicial discretion, should review, and it is respectfully submitted that this petition for a writ of certiorari should be denied.

Respectfully submitted,

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